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Caring Revisited: A Foucauldian Discourse Analysis on the Association of Caring with the Profession of Nursing

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Nursing

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Abstract

There have been numerous theories put forward by nursing theorists on the importance of caring in nursing. Very few studies have looked at the impact that this association has on the practice of nursing. This study will add to the existing literature by using a Foucauldian discourse analysis to examine the material effects that the caring discourse has on nurses' ability to advocate for safe working conditions during a public health emergency. Using the outbreak of COVID-19 in Ontario, Canada in the Spring of 2020 as a context, this study seeks to establish caring as a discourse and examine how that discourse may impede nurses' ability to protect themselves from harm. The results of this analysis explicate how public media discourses that position nurses as caring, altruistic, and heroic may have impacted their ability to maintain their personal safety as a result of the expectations put upon the nursing profession.

Keywords: caring, discourse, analysis, Foucault, nursing, COVID-19, Ontario, Foucauldian, PPE, personal protective equipment

Summary for a Lay Audience

Caring is often discussed both within and without the nursing profession, but it remains an ill-defined concept. There is an historical association between the idea of caring and nursing, but the impacts on the actual practice of nurses has not been examined extensively. A discourse analysis offers a mean to look critically at this association by tracing the evolution of the idea throughout the literature for fixed period of time. This project is important for the nursing profession as the impact of this discourse on the nursing profession has not been examined and helps to bring to light how the general public's ideas about caring and the nursing profession may be shaping the profession to this day. Using the outbreak of COVID-19 as a context, this study seeks to determine if the association of the discourse of caring with the nursing profession may have impacted the safety of nurses in Ontario, Canada to advocate for safe working conditions, during the early stages of the pandemic. This study seeks to add to the existing body of knowledge by demonstrating how the effects that ideas such as caring can impact nurses directly and materially.

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Caring Revisited: A Foucauldian Discourse Analysis on the Association of Caring with the Profession of Nursing

Chapter 1: Introduction & Background

The perception that nursing is a caring profession is a seemingly ubiquitous one in North America, but it is also one that has sparked much debate (Finfgeld-Connett, 2008). Both non-nurses and nurses alike often assume that caring is one of the foundations of the profession, and caring is discursively positioned as an assumed good. In fact, “caring” is listed by professional organizations as foundational to the practice of nursing (American Association of Colleges of Nursing, 2008; Registered Nurses’ of Ontario [RNAO], 2002). The College of Nurses’ of Ontario (CNO) and the Registered Nurses’ Association of Ontario (RNAO) both cite the importance of caring in the profession (for examples, see CNO, 2018; CNO, 2019c; RNAO, 2002; RNAO, 2015), but do not provide any definition of the term. Caring is often presented as a normative value in nursing textbooks and in the education of nurses (Dahlke & Wall, 2017). The prevalence of caring in the nursing literature can give the impression that caring is a necessary personality trait for any person wishing to become a nurse. Nursing theorists have developed numerous theories about its function in nursing (Blasdell, 2017) and caring has been referred to as the essence of nursing by nursing theorists, such as Jean Watson and Madeleine Leininger. However, there are a number of nursing theorists who disagree with this association of caring with nursing for reasons that I will discuss below (for examples, see Barker, Reynolds, & Ward, 1995; Dahlke & Wall, 2017; Gordon & Nelson, 2006; Paley, 2001). In spite of an abundance of literature on the topic, there is currently no consensus on whether or not caring is an essential component of the nursing profession.

Part of the confusion may stem from the different meanings of the words care and caring, with very little distinction between caring as a personal inborn trait (to be caring) or an act (i.e. to provide care). Nurses will often use the word care to refer to any act that they perform on a patient's body. For example, a nurse will provide patient care throughout the day. This care can include technical skills, such as managing drains or monitoring oxygen levels, or refer to acts such as helping the patient eat or helping the patient bathe. Caring as a concept, on the other hand, may refer to personality attributes, interpersonal relationships, holism, nurses' mental well-being, morality, ethics, emotional labour, and is very often discussed in terms of things that are said about nursing, rather than to what nurses actually do (Dahlke & Wall, 2017; Delgado, Upton, Ranse, Furness, & Foster, 2017; Finfgeld-Connett, 2008; Paley, 2001). In this study I will argue that caring is also a discourse that organizes and constrains how we think about nursing as a profession and how we think nurses should behave.

While there are many theories regarding the placement and meaning of caring in nursing, there are few that look at the historical origins of this association and that examine the impact these origins have on the profession today. Etymologically, the origins of the word "nurse" is related to the word "nurturance", which may act a basis for the connection between the two words (Blasdell, 2017). The historical roots of the discourse of caring positions caring within the discourse of feminine love, and associates caring with acts of self-sacrifice, altruism, motherhood, morality, virtue, and even love (Dahlke & Wall, 2017; Dunlop, 1986; Gordon & Nelson, 2006; Reverby, 1987). Whether or not this historical association impacts nurses today in any material way has not been studied. Therefore, this link between the profession of nursing with the discourse of caring needs to be scrutinized for relevance to the present-day realities and responsibilities of nursing. It has also been suggested that a discourse analysis would be a

suitable methodology to conduct an examination of the association of caring with the profession of nursing, due to the historical origins of this association (Skea, 2015). For this reason, the methodology that I have selected to conduct this study is a Foucauldian discourse analysis (FDA).

The outbreak of SARS-CoV-2 (COVID-19) in Ontario in the spring of 2020 has provided a context that may help to highlight some of the ways that caring may impact nurses in the workplace. A public health emergency of this magnitude has helped to bring certain issues to the forefront, such as a nurse's ability to advocate for safe working conditions. The material impact of the discourse of caring is important to consider during situations such as a pandemic, when safety should be of the utmost importance.

1.1 Study Purpose & Rationale

The purpose of this study is to explore how and “make strange” (Gee, 2014) how the concept of caring enters into the popular media accounts of nursing during a pandemic and to map the impact this has had on issues such as a nurse's ability to work safely. If nurses are taught that the essence of nursing is caring, how does that impact nurses while they are at work? Also, does that affect how nurses are treated by our employers and various regulators of the profession, such as the College of Nurses of Ontario and the Ontario Ministry of Health? Using the experiences of nurses during the COVID-19 outbreak in Ontario in the Spring of 2020, I intend to look at the ways that the discourse of caring has impacted the ability of nurses to keep themselves safe. The material impact of caring in nursing is important to consider during situations such as a pandemic, when safety should be of the utmost importance.

1.2 Genealogy and History of the Present

In lieu of the more traditional literature review, I am presenting what Foucault termed a genealogy followed by a history of the present. This is very similar to a literature review but is more historically situated than a traditional literature review. This specific terminology will be explained in a bit more detail further on, but, in short, this section will detail a brief history of the discourse of caring, culminating in the present conceptualization of the term and discourse in relation to the nursing profession. This section will provide the context for the thesis and provide readers with an overview of how caring has been viewed historically in relation to the nursing profession. Some key components of the discourse will be identified.

I will begin my review by considering the discourse of caring beginning at the point that most nursing theorists consider to be the advent of modern-day nursing: the writings and work of Florence Nightingale (Reverby, 1987; Adams, 2016; Beck, Dossey, & Rushton, 2013; McDonald, 2014). Nightingale did not strictly view caring as being within the scope of nursing duties. In fact, Nightingale's seminal text on nursing (*Notes on Nursing*, 1860) does not actually discuss "caring" at all. Nightingale does discuss "care" in her works but tended to use the term more in the sense of "caring for" rather than as an individual attribute of "being caring". For example, Nightingale writes, "All these things require common sense and care," when writing about providing nursing care to weak patients (Nightingale, 1860, p. 11). Caring was not something she ever specifically stated was within the purview of the nurse and was certainly something she focused less and less on as time went on (Adams, 2016). Nightingale believed that nursing was a duty or a calling, yet she never explicitly made the link between caring and nursing (Nightingale, 1860). However, her reference to nursing as a calling is somewhat reminiscent of being called to a religious order. This association is not arbitrary, as religious orders such as nunneries were also well-known for treating the ill (Gordon & Nelson, 2006).

This association between religion and nursing provides a space for the discourses associated with religiosity (such as caring, self-sacrifice, and altruism) carried over into the nursing discourse (Gordon & Nelson, 2006).

Nightingale broke gender stereotypes by positioning nursing as a means for women to work outside the home without upsetting existing gender norms, as nursing offered one of the few legitimate ways for women to work outside of the home that would not threaten the male dominated profession of medicine (Roberts & Group, 1995a). In addition, the structure of the hospital setting and the teachings of Nightingale herself ensured that nurses would remain subservient to physicians (Roberts & Group, 1995a). Nightingale herself believed that nurses were meant to act as the eyes and ears of the doctor, but should not act in place of the physician, or even necessarily question the physician (Aranda & Brown, 2006). In this way, the role of a working nurse was one that fit within the existing gender norms of Victorian society. Victorian middle- and upper-class society was organized around the idea that women were the caretakers of the home (the private sphere) and men were to keep charge of any worldly affairs that took place outside of the home, including paid work (the public sphere) (Hawkins, 2010a). It was believed that women required protection from the evils of the public sphere, meaning work and life outside of the home was generally prohibited, except in very specific circumstances (Hawkins, 2010a). In practice, it was generally women of the middle class and above who were able to follow this prescribed way of living, as women in the lower classes had no choice but to work outside of the home, and upper-class women had little need to work (Hawkins, 2010a).

Prior to the American Civil War, any woman could claim to be a nurse, as it was believed that women naturally knew how to care for the ill (Lewenson, 1993). Women were the traditional caretakers in the family; if there was a sick relative, it was the females in the

household who assumed care of the ill (Reverby, 1987). Therefore, society already viewed women as the natural caretakers (or caregivers) within the family and putting them to work as nurses was a logical extension of this role (Reverby, 1987). It can therefore be said that Nightingale did not explicitly initiate the modern-day association of caring with nursing, nor did she even engage with the discourse, since the belief that women were natural caregivers was already a dominant one at that time. Nurses were not trained to “care” because it was assumed that they automatically would (Dahlke & Wall, 2017). The female duty to care was therefore already entrenched in societal gender norms and roles, and this association was carried over into the profession of nursing. The assumption of caring was therefore already so embedded within the idea of nursing as a result of these traditional gender roles that it did not require explicit reference. This historical analysis might explain the seemingly a priori placement of caring in nursing; if caring was considered to be the duty of women at the establishment of what can be considered modern-day nursing, it is possible that the current association of caring with nursing is a remnant of this.

Obtaining information on nursing in the first half of the 20th century can be challenging, as nursing education was not yet unified across North America and teaching materials varied from school to school (Peplau, 1999; Ruby, 1999). This fact is exacerbated by the fact that there are very few published critical analyses of historical nursing texts (Walker & Holmes, 2008). However, as a profession, nursing was founded on very conservative values that were grounded in gendered ideas around what women were good at doing (Walker & Holmes, 2008). Walker and Holmes (2008) state that nurses took on a “sacrificial” role, both towards the physician and the patient. Subservience to the physician was expected (Peplau, 1999). “Womanly” attributes (tenderness, cleverness, motherliness, etc.) were praised as good qualities for a nurse to have

(Walker & Holmes, 2008). The same qualities that were present in a “good woman” in Victorian society were also meant to be present in a nurse (Walker & Holmes, 2008, p. 111). These qualities were inherent; they could not be learned, only strengthened (Walker & Holmes, 2008).

In an effort to find literature associated with caring from the first half of the 20th century, I conducted a search of the database for the *American Journal of Nursing*, the oldest existing nursing journal, for any works that contained the word ‘caring’ in either the title or the abstract, with a publishing date parameter of 1900-1960. Once duplicates were removed, a total of 10 articles were returned, none of which discussed the theoretical basis of caring. For the most part, caring was most often used in these texts as a substitute for “working with” (for examples, see Harden, 1953; Stypul, 1948; Weaver, 1926). However, one article discussed the ways that a nurse could go about demonstrating to older adult patients that the nurse really cares about them (Merritt, 1952). Some of the suggestions were placing a flower on their meal tray, decorating their room with get well cards, asking the family for food preferences, and to never act in a rushed manner (Merritt, 1952). A nurse’s purview appears to be limited to providing creature comforts to patients. A nurse demonstrated caring through the provision of little extras, such as flowers, tailoring service to meet the patient’s preferences by asking about them, and by providing their time to their patients, without appearing rushed. While caring is not mentioned specifically by the author, it is possible to look at these acts as one way of demonstrating care.

Another article, written by an obstetrician in 1957 (who was a male physician), detailed the ways that nurses can increase their ability to care for obstetric patients. His suggestions included telling the patient what is going on, massaging the patient’s back during contraction, applying cool cloths as necessary, and to provide overall support (Goodrich, 1957). Goodrich then goes on to suggest that simply providing a good experience without any discomfort should

give the nurse “personal satisfaction” (1957, p. 588). This is an excellent example of a physician writing how he perceives that nurses can achieve the most amount of satisfaction. In this case, the physician decided to speak for nurses by telling them what was best for them, which, coincidentally, was also likely best for his patients, and also in line with gendered ideas about how to achieve personal satisfaction. In this instance, making patients comfortable and happy are equated with the personal, not professional, satisfaction of the nurse. Again, caring is not specifically mentioned by the author, but there is an implication that making other people happy is one way that nurses can achieve some type of happiness.

One nursing theorist who worked during the first half of the 20th century has given her insights into nursing at that time. Peplau (1999), who became a nurse herself in 1931, provides an excellent personal history of the development of the nursing profession. Peplau states that between 1900-1930, nurses were completely under the purview of physicians and a nurse’s primary role was to act as a helper to the physician. Nurses were not meant to exercise their own judgment but were instead there to simply carry out the physician’s orders (Walker & Holmes, 2008). This fact was exacerbated by the fact it was physicians, not nurses, who provided nursing education. Physicians therefore had total control of the content that was taught in nursing schools (Peplau, 1999; Ruby 1999). This gave physicians the power to tell nurses what their job was and how to perform it. It also gave them the power to withhold information from nurses. During this period nurses were seen as intelligent, but not intelligent enough to understand a medical text; nurses were not generally provided with too much medical knowledge, for fear it might confuse them (Walker & Holmes, 2008). The subservience of nurses to physicians was an entrenched practice in the profession at this time. Caring was not discussed, as there remained a strict gendered division of duties. However, caring was not a part of the education provided as it was

assumed that nurses (as women) were already naturally caring (Anthony & Landeen, 2009; Dahlke & Wall, 2017).

However, Peplau states that nurses were generally comfortable with being viewed as “self-sacrificing”, as to become a nurse was often used as a means to escape from poverty or lower-paying careers (Peplau, 1999, p. 32). New nurses were viewed as malleable and docile by physicians, upon whom they could imprint their ideas with little chance of being challenged (Andrist, 2006a; Peplau, 1999). Nurses were not meant to voice their own opinions, and the result was that nurses were routinely silenced and essentially invisible (Walker & Holmes, 2008). Nurses had little agency, as both physicians and hospitals laid out many rules to dictate their behavior (Walker & Holmes, 2008). This situation was a boon for physicians, as having nurses on hand to perform the actual work, physicians were free to pursue research, experiment, and develop new techniques (Peplau, 1999). This observation echoes the representation of physicians in the archive, who were more likely to be depicted as conducting research or performing technical work.

From 1930-1945, nurses were essentially replaced by medical residents. Residents, by virtue of being male, received more interest from the physicians, and took over many of the duties that would have traditionally been given to the nurses (Peplau, 1999). Conservative, gendered ideas around work dominated (Andrist, 2006a). Nurses were beginning to focus on the needs of the patient instead of the needs of the physician and were also arguing for more autonomy, marking a turning point in their relationship (Peplau, 1999). Physicians, in turn, became more focused on controlling the actions of the nurse, and what Peplau described as a “surrogate family situation” began to deteriorate (Peplau, 1999, p. 33). This analogy to a surrogate family echoes what Hawkins (2010a) writes about late 19th century hospitals. The

family metaphor was extended to hospitals, placing males/physicians in charge and nurses in a supportive/subordinate role (Hawkins, 2010a). A nurses' traditional role was beginning to be re-evaluated and by the 1950s, there was no clear consensus on what nursing even was (Aranda & Brown, 2006; Orem & Taylor, 2011). However, the link between caring and nursing continued through to the 1960s (Dunlop, 1986).

One of the earliest caring theories developed during this period. In 1959, Dorothea Orem's Self-Care Deficit theory was published. The theory arose out of questioning around how to define the purpose of the nursing profession (Orem & Taylor, 2011). The role of the caring nurse was being challenged, but there was little agreement on what to replace the concept of caring with. Orem's theory of self-care was organized around the idea that patients should be viewed holistically, and that nurses should allow clients to perform as much care for themselves as possible, and only step in when necessary (Denyes, Orem & SozWiss, 2001). Orem's theory emerged at a time when nursing was viewed very much as a practical science (Denyes et al., 2001). Patients were taught to care for themselves through the nurse. In this theory, it is the nurse who dictates what the patient does and does not need. The nurse supplies the patient with the tools to achieve the prescribed requisite level of self-care. In this case, the onus of caring is directed back at the patient, with the nurse there to act as a guide. Caring as a personal attribute of the nurse is not discussed in this theory, but Orem's theory gives a nod to it by placing the nurse in charge of the patient's progression by teaching them to care for themselves.

By the 1970s, the second wave of feminism was in full-swing and gender roles were being closely examined. Nursing was denigrated by some feminists because it was viewed as a profession that had institutionalized the image of the subservient woman (Roberts & Group, 1995b). At that time, there were certain authors who believed that there were essential

differences between men and women. For example, Carol Gilligan's seminal work *In a Different Voice* (1982) focused on the different ways in which men and women responded to moral and ethical dilemmas. Her conclusion was that men tended to resolve issues more abstractly, whereas women tended to look for more concrete solutions tailored to the situation that caused the least amount of suffering to all involved. Through the words of her study participants, Gilligan links feminine morality to ideals such as "good" (equating good with caring for others), a morality that is averse to hurting others, and responsibility that is linked to situational selflessness. In a similar vein, Noddings (1984) examines how feminine morality and caring are intertwined; she also believes that morality is linked to caring due to the fact that women are more inclined to deal with moral dilemmas in a concrete manner rather than referring to more abstract (or generalizable) morality (Noddings, 1984). Noddings actually addressed the issue of caring in nursing directly, praising the theorists who put caring at the forefront of the nursing profession (Noddings, 1990). Ultimately, both Noddings and Gilligan approached caring from the standpoint that masculine and feminine approaches were binary categories and essentialist, i.e. women were born "feminine", and men were born "masculine". By the end of the 1970s, the concept of caring had been deemed to be the essence of nursing by numerous prominent nursing theorists (Aranda & Brown, 2006), again evoking an essentialist understanding of the concept. The idea that the individual sexes each had attributes that were biologically determined echoes the ideals of the Victorian Era (Cordea, 2013; DeFrancis, 2005; Mosedale, 1978).

By the 1980s, caring had taken root in nursing and was positioned as intrinsic to the profession by many theorists (Paley, 2002). Contemporary authors writing about the importance of caring within nursing will often discuss the association between morality and caring (Griffin, 1983; Newham et al., 2019; Blomberg, Griffiths, Wengström, May, & Bridges, 2016; Gastmans,

1999). As discussed above, this association between caring and morality was echoed in some of the feminist philosophy of the 1970s and 1980s, and this link remains present in much of the literature today.

In the 1970s, Madeleine Leininger began to develop her transcultural theory of nursing. She continued to develop the theory throughout the 1980s. Leininger described caring as the essence of nursing and established what became known as Caring Conferences in 1978 (McFarland, 2012). Leininger's theory of caring posited that caring occurs across all cultures, and it is a nurse's duty to exhibit caring in the culturally appropriate manner (Clarke, McFarland, Andrews, & Leininger, 2009). It was Leininger's core belief that caring was the essence of nursing that led to the development of this theory and all components of the theory are built upon this assumption (Clarke et al., 2009). Leininger viewed caring as essential to the profession, but also acted to integrate the new realities of the world, such as increased contact with other cultures due to the development of air travel. Leininger's theory of caring remained based in the idea that caring was essential to nursing but developed this idea to more accurately reflect the time period. Leininger's theory of caring positions caring as a tool that can cross cultural boundaries. However, it also stipulates that at least some aspects of caring are culturally specific.

Dr. Jean Watson began developing her theory of caring in the 1970s and is one of the more influential caring theorists active in the field today (Aranda & Brown, 2006). Today, Watson (2012) asserts that nursing is a mixture of art and science that remains distinct from the medical model. The nursing model is founded on the ideals of holism, which for some includes the idea that the nurse is morally bound to care to their patients (Watson, 2012). In Watson's view, nursing deals with "expanding human consciousness" with a focus on the "human-environment field, unitary person...spirit" (Watson 2012, p. 17). This focus on the metaphysical aspect of

nursing is not confined to solely to Watson. Rosa, Estes, and Watson (2017) argue that nursing is able to transcend the medical model by focusing on the more metaphysical aspects of being, such as connectedness and the unity of all living things (Rosa, Estes, & Watson, 2017). Caring, they conclude, transcends time, physicality, and space. Furthermore, the act of caring does not only aid the patient; it can evolve the nurse to higher levels of consciousness (Rosa et al., 2017).

Therefore, it is not only the patient that benefits from the act of caring. In fact, the authors state that caring science is concerned with the “evolution of human consciousness”, implying that caring is a means to greater spiritual awakening and knowledge (Rosa et al., 2017, p. 62).

For Watson, nursing becomes an act that arises from the metaphysical world, incorporating theories of ontology and quantum cosmology within its fold (Watson, Smith, & Cowling, 2019). As with any metaphysical theory, caring acts are thought to transcend the phenomenal and material world (Adams, 2016). The human spirit and the universe are both infinite energies, and the transformation of these energies can only occur within interpersonal relations (Watson, 2012). Caring is viewed as part of the healing process for patients, but also as a means for the nurse to achieve unity with humankind and the universe (Watson et al., 2019).

In Watson’s caring science, caring is also linked with the Buddhist tradition of mindfulness with nursing (Sitzman, 2019; Wolf & Turkel, 2019; Horton-Deutsch, Oman, & Sousa, 2019). The tradition of mindfulness in Buddhism is meant to provide a link between body, mind, and practice (or action) (Khoury et al., 2017). In caring science, mindfulness is meant to increase the nurse’s compassion (Giovannoni, 2019) and create a space for a nonjudgmental presence in the moment (Perkins, 2019). Watson’s caring theory positions caring as a means to empower and heal, but also as a means to connect with the universe.

Another development in the world of caring literature that began in the 1980s and have continued to some degree ever since are caring scales. While many different scales have been developed, for the most part they are meant to quantitatively identify how much caring has been provided by the nurse. Generally speaking, it is the patient's perception of caring that is sought, although sometimes the nurse is asked for their input as well (Tatano Beck, 1999). Caring scales have been developed over the decades as a means to try and measure how much caring has been provided (Tatano Beck, 1999). Each scale has its own conceptualization of what caring is (Tatano Beck, 1999). For many scales, caring is viewed as a therapeutic intervention and rely on a patient's perception of the nurse's provision of caring behaviors (Tatano Beck, 1999). It would seem that caring scales attempt to bring caring into the world of the quantitative, where cause and effect can be accurately measured.

In 1989, Benner and Wrubel developed a theory of caring that was published in 1989. In their view, nursing was both a science and an art (Spichiger, Wallhagen, & Benner, 2005). Their theory of caring drew heavily on Heidegger's notion of *sorge* (or care), a highly abstract ideation of caring that removes much of the sentimentality that we tend to association with the word caring, placing caring into the sphere of the ontological (Edwards, 2001). Heidegger used caring in a way that is not typically associated with nursing; he was in fact pointing to a way of being involved with the world (Dunlop, 1986). Heidegger's conceptualization of care positions the attribute of caring as neither good nor and is more akin to interest or concern (Dunlop, 1986). Benner and Wrubel contend that in order to be an effective nurse, nurses must know what a patient cares about (Edwards, 2001). Nurses are to provide care to patients by understanding what is important to the patient. Intention is removed from the act of caring, even while care is developed and cultivated. Care instead becomes about directing attention towards something or

someone who is of interest, specifically because they are a patient and nurses are supposed to demonstrate interest in patients (Edwards, 2001).

In Benner and Wrubel's theory, a nurse's caring was directed at determining what matters to the patient, how the illness may affect what they care about, and what coping abilities they may have to deal with any changes or losses they may have around what they care about (Spichiger et al., 2005). Providing care remains focused on the patient, but also retains the idea that the nurse becomes immersed in the patient's world (Orlick, 1988). In order to provide care effectively, the nurse must care about what the patient cares about. The methods of caring that the nurse may use must remain fluid so that the nurse can adapt any situation (Spichiger et al., 2005). With echoes of Orem's theory of self-care, caring is situated firmly in the patient's world, with the nurse only there to help the patient develop autonomy and to facilitate any necessary transitions (Spichiger et al., 2005). In this theory, the focus remains on the patient, but there are no prescriptive actions that the nurse can take; in fact, prescriptive acts are discouraged (Spichiger et al., 2005). However, nursing remains a moral act, as the goal is to facilitate the patient's goals (Chinn & Kramer, 2018). Benner and Wrubel's theory positions caring as a tool that helps nurses to help patients, but they are non-specific around how to achieve that goal. Caring is reframed as concern, with judgments around good and bad removed. However, the formulation of nursing as a moral duty remains, committing the nurse to continue to care.

Ray and Turkel's (2014) Relational Caring Complexity theory states that nurses have a moral duty to enact what they call a social caring ethic. These ethics are grounded in the tenets of emancipation, social justice, and human rights. Nursing is linked with these acts as a means to care for all of humanity (Ray & Turkel, 2014). Social justice and human rights are cited as the core components of a democracy, and it is a nurse's job to try to uphold these values within the

healthcare setting (Ray & Turkel, 2014). Nursing is framed again as a profession that focuses on holistic values (Ray & Turkel, 2014). Ray and Turkel's theory positions caring as an ethical mandate of nursing meant to further the evolution of human society by giving those with less power access to means to improve themselves. Caring is positioned as an emancipatory act, with the nurse essentially at the helm, helping others overcome oppression.

Swanson published her theory of caring between 1991 and 1993 and the theory is underpinned by a commitment to the tenets of holism (Andershed & Olsson, 2009). Swanson's caring theory was inspired by Watson's work (Andershed & Olsson, 2009). Caring is seen as a way of relating to others in a nurturing way, encapsulating the traits of commitment and responsibility to others, and the purpose of which is to give a space to another's capacity to grow or heal (Andershed & Olsson, 2009). Swanson's theory of care focuses on centering on the patient, avoiding assumptions, engaging and knowing the patient, emotional presence, conveying a sense of availability, and sharing feelings with the patient (Swanson, 1995). Swanson's caring theory positions the nurse's emotions as a means to promote patient healing, without necessarily recognizing the toll that this can take on the individual providing care. Here, caring is an emotional act that promotes holism.

Falk-Rafael (1998) posited three types of caring: ordered caring, assimilated caring, and empowered caring. Ordered caring was centered on the relationship between caring and power, with power controlling those who cared (Falk-Rafael, 1998). Assimilated caring positioned nurses to internalize the dominant discourse, thereby not so much usurping the current power structure as becoming complicit with it (Falk-Rafael, 1998). It was with empowered caring that nurses could come into their own. Empowered caring recognizes the power of caring; nurses are meant to embrace the determinants of health of construct their own power networks in order to

foment change (Andrist, 2006a; Falk-Rafael, 1998). It was the concept of empowered caring that allows nurses to move the profession forward, using the power of caring. Caring is given a place of primacy in this theory, with the belief that it will help to propel the profession forward. Caring is again posited as emancipatory, certainly for the patient, but also for the nurse via the construction of their own power networks.

These more contemporary caring theories have generally attempted to remove some of the more unpalatable earlier associations with caring, such as subservience, love, and duty. These words have been replaced with ideas such as ethics, morality, metaphysics, social justice, nurturing, therapeutic relationships, and even a theory of caring that attempts to make caring a detached, non-emotional part of a nurse's work. The focus is instead directed onto the patient and, in some theories, the nurse. There can also be a metaphysical focus describing occurrences such as transfers of energy, loving-kindness, faith, forgiveness, and co-creation, among other things (Watson Caring Science Institute, 2020). Caring has been re-positioned as a tool that nurses can use, but without addressing the historical association of the term with the profession. In addition, the emotional labor of caring is an unrecognized aspect of many of these theories, and the addition of this type of labor may impact the nurse mentally, emotionally, and physically (Delgado et al., 2017; Valiani, 2003).

The language used by contemporary nursing theorists when discussing caring now may be different from the language of the Victorian past, but in some ways their work reproduces the more traditional norms related to the gendered expectations related to women and caring. Women were routinely expected to "care", and self-sacrifice was an aspect of these expectations. Caring has been repositioned by contemporary authors as empowering, transcendent, emancipatory, nurturing, moral, but also still as a duty of the nurse in some theories. Some of

these words are reminiscent of the ways in which caring was conceptualized in the Victorian era. Caring is viewed as something that not only helps the patient, but also as a tool that can help the nurse to become a better person. Caring is being presented as a means for the nurse to achieve self-worth and a sense of purpose. Caring is put forth as a positive attribute (which is certainly can be), but at the same time it is being presented as a duty of the nurse. If caring is the essence of nursing, then to go against it is to go against duty. Caring, therefore, remains a duty of the nurse, as it was during the Victorian era.

A discourse inevitably carries its history along with it. While nurses may have moved on and have started to re-frame what caring means to the nursing profession, the long historical association of the term with the profession means that the original assumptions of the discourse remain embedded within the discourse (Mills, 2003). What has occurred is that caring has been made more palatable for a more modern audience. For example, self-sacrifice may be removed from the more contemporary conceptualization of caring, but, once again, there are undertones of it within some of the contemporary theories. The nurse is meant to embrace caring not only for the patient's sake, but for their own self-development, to achieve social justice, as a moral duty, or simply to help to nurture other people. These themes can be related back to the Victorian conceptualization of womanhood.

There also remains a strong conflation of the personal and the professional in this ideation of caring. There is a tendency in these theories to conflate the personal with the professional. For example, caring has been equated with the evolution of humankind (Leininger, 2013) or described as a metaphysical process that is spiritual, even cosmic, in nature, and transcends time, space, and place (Watson Caring Science Institute, 2020). These are both big ideas that are perhaps more suited to the realm of the personal, rather than the professional. This conflation of

the personal with the professional may have a detrimental effect on a nurse's perception of self should they not feel successful at "caring" (Dahlke & Wall, 2017).

For some caring theorists, such as Watson, caring remains a calling, a necessity, a tool that the nurse can use to fulfill their life goals with. Unfortunately, this retains the strong gendered sense of the conceptualization of caring that was present in the Victorian Era. The discourse has moved on from stating that caring is a biological attribute and has instead moved into a more spiritual realm, promising fulfilment for the nurse. Caring, as Watson conceptualizes it, can provide spiritual fulfilment and expand the nurse's consciousness. The idea that caring can elevate the consciousness of the nurse and ultimately make them a better person can be likened to the Victorian ideals that self-sacrifice and altruism are inherent attributes of any nurse, and that acting self-sacrificially fulfils a deep-rooted, biological desire (Mosedale, 1978). These contemporary caring theories suggest that nurses act in a caring, self-sacrificial manner by putting the needs of others above their own with the promise that it will fulfil them spiritually, professionally, and morally. According to the above permutations of the discourse, the benefits of acting in this way will lead to enlightenment or a sense of moral accomplishment for the nurse.

The discussion here has focused on the history of the discourse of caring and on the ways that the discourse has changed over time. What we can see is that the discourse of caring has not been removed from nursing. Instead, the discourse has changed to reflect more modern values, with references to subservience removed. This is congruent with Foucault's assertion that discourses do not disappear, but instead simply change over time to more accurately reflect the social norms of the day (Mills, 2003). However, some terminology associated with earlier versions of the discourse, such as references to sacrifice, duty, morality, and altruism, has

remained. I will now discuss the ways that some contemporary authors argue against the positionality of the caring discourse within the nursing profession.

1.3 Critiques of Caring in Nursing (Dissenting Discourses)

It was primarily during the second wave of feminism in the 1970s that critiques around the role of caring in the nursing profession came into discussion in the literature. Women in North America were calling for equality, both at home and in the workplace (Evans, 1995; Zeitz, 2008). Female dominated professions, such as nursing, were identified by some feminist authors as areas that were due for change (Andrist, 2006a; Romero & Pérez, 2016). As noted previously, some authors such as Noddings (1984, 1990) attempted to explain the difference in genders by essentializing them, attributing differences to biology (Evans, 1995). At this time, the nursing profession was scrutinized due to the perception of nurses being considered to be subordinate to physicians, and nurses were criticized for perpetuating this role of inferiority (Andrist, 2006a). While some nurses certainly participated in the second wave of feminism, this particular period was marked by a tone of general disparagement towards the profession from many mainstream feminists (Andrist, 2006a). While caring was not necessarily discussed specifically, the perceived tenets of the nursing profession certainly were. The attributes associated with nursing, such as caring and subservience, were identified by some authors of the day as gendered and requiring change (Andrist, 2006b).

Author John Paley has written extensively about the placement of the caring discourse within the profession of nursing. He writes that caring is ill-defined, remains without substance (Paley, 2001) and that it was promoted as the essence of nursing only as a means to directly oppose the medical model (Paley, 2002). The medical model is the model that physicians use, and it is based on the idea that all disease is a deviation from normal. The medical model has

been criticized for being reductionist, due to the fact it focuses solely on the biological functions of human beings, instead of viewing people more holistically (Fuller, 2017). Paley (2002) argues that by rejecting the tenets of the medical model, nursing theorists are implicitly labelling the medical model as “bad”. In doing so, nurses are placed on the moral high ground (Paley, 2002). Paley (2002) argues that nursing instead could be defined as a profession centered on the recovery and rehabilitation of people.

Barker, Reynolds, and Ward (1995) argue that “caring science” reads more as an ideology or theology than a science. As discussed earlier, in some cases the arguments for caring in nursing are so broad that they transcend the profession of nursing and enter the metaphysical sphere (Barker et al., 1995). References to chaplains or mystics in the caring literature has a tendency to lend it a religious tone that grounds it in religious ideology instead of science (Barker et al., 1995). Barker, Reynolds, and Ward do not view this focus on the metaphysical positively and argue that the usefulness of caring in the nursing profession is never adequately questioned. Paley (2002) takes this argument one step further and states that the hyperbole surrounding caring in nursing essentially attempts to place nurses on the cusp of saving humanity through their profession. The similarities to religious ideology and reference to metaphysics places the professional values of nursing within the personal, turning this into a discussion centered more on personal values than professional ones.

In one of the few articles that addresses how caring impacts the daily work habits of nurses, Dahlke and Wall (2017) hypothesize that the focus on caring might actually impede nurses from raising their concerns about certain workplace practices out of the fear that they might not be performing up to the ideal of caring. For example, some nurses view the use of restraints as anathema to caring, as it distresses the patient and can lead to patient injury (Dahlke

& Wall, 2017). However, there is a rationale that the use of restraints is ultimately a caring behavior, since it keeps the patient safe, and keeping a patient safe means that you care about them (Dahlke, Phinney, Hall, Rodney, & Baumbusch, 2015). However, the rationale behind the reframing of difficult practices as caring behavior does not provide any benefit to the patients. Instead, it reframes an action that instead is perhaps not inherently good or bad, into one that is centered around caring (i.e. good). A more straightforward rationale might be that restraints are used for reasons of safety. In addition, reframing the use of restraints takes the focus off of the patient and places the focus on the nurse. While defining the use of restraints as an act of caring may help a nurse feel better about their actions, particularly if the patient is strongly objecting to the practice, it does little else. This example highlights the tension between wanting to be viewed as an efficient nurse and a caring nurse, as the two are not always commensurate to one another (Dahlke & Wall, 2017).

Authors that dissent with the discourse of caring have not been subsumed within the caring discourse, nor do they need to be. The abstract and often vague nature of the definition of the word caring essentially makes those who argue against it take aim at a moving target. Arguments against the idea that caring is the essence of nursing can be argued against by simply re-framing the idea of what caring is. In addition, the sheer number of caring theories make it difficult to easily counter all of the pro-caring arguments. Any type of criticism can be revoked with yet another formulation of what caring actually is. The discourse of caring continues to be re-invented, allowing for multiple caring theories to co-exist all at once without necessarily contradicting one another, in spite of the fact that they are all different from one another.

In the next chapter, I will discuss the methodology that I used to conduct this research. Some of the topics I will cover include the theoretical foundations of discourse analysis. The

provision of these definitions and goals will help the reader understand the overall purpose of this analysis as well as the reasoning behind selecting the FDA as a methodology.

Chapter Two: Methodology

Discourse analysis was selected as an analytical tool for exploring the association of caring in nursing in relation to the COVID-19 2020 pandemic because the term has been associated with the nursing profession for at least 100 years. In addition, the importance of the concept is still visible in the nursing literature. Nursing theorists who write about caring cite caring as the essence of nursing and a copious amount of text is dedicated to exploring this concept. However, caring is a constituted concept; that is, it is comprised of many different ideas and concepts. Therefore, what caring looks like in practice may be different for everyone. The historical association of caring with nursing coupled with the inexact definition of the term indicated to me that there was some unpacking that needed to be done. What interested me the most was how the historical conceptualization of caring may have formed the more modern conceptualization of the profession. As I will discuss here, a discourse analysis is an ideal medium for tracing the evolution of a concept, all while looking at it in a critical manner. Here, I will provide some general definitions, and discuss the theoretical foundations of the method.

2.1 What is a Discourse?

The definition of discourse is somewhat fluid. Generally speaking, a discourse is “a common set of assumptions that are typically taken for granted, invisible, or assumed” (Cheek, 2004, p. 1142). Put in another way, a discourse is both a composite of and repository for societal norms. Not all discourses hold the same sway or are under the influence of the same amount of power (Cheek, 2004). That is, not all discourses are created equally; some can be considered to be dominant while others may be considered to be sub-dominant or alternative.

Discourses are perceptible because they operate systematically and have an effect on ways of thinking and being (Mills, 1997). Discourse is an effect of power, in that it can be used

to legitimize certain modes of knowledge and power (Hook, 2001). The societal norms established by those who have the power to guide the discourse ultimately end up defining the subjects of the discourse. For example, nurses are often thought of as caring individuals, both by the public, professional organizations, and may be portrayed as such the nursing literature. These representations may form the development of the nurse (the subject) and may also influence how society views nurses in general. The discourse can therefore be said to be productive, in that it can produce subjects through the proliferation of concepts (Mills, 1997).

All of the choices that we make on a daily basis surrounding what words to use and what words are not appropriate are decisions that we make based on our ideological outlook and interpretation of societal norms (Colebrook, 2000). Discourses therefore set the parameters both for what we can and cannot say. The result is the discourse, which is an accumulation of societal norms around a specific subject. Any assumptions made about societal norms and behaviours are an example of how the discourse functions to discipline its population (Crowe, 2005). A discourse is also productive, in that it can produce statements, effects, or concepts (Mills, 1997). There is a systematicity present in the texts related to the discourse, resulting in speech and action that mobilizes power and allows for knowledge to be gathered about the subjects of the discourse (Powers, 2013). The association of caring with the nursing profession can certainly be considered a discourse, as this association appears to be grounded in societal beliefs, as opposed to science, and is therefore representative of a strongly held social norm.

2.2 Discourse Analysis

Broadly defined, a discourse analysis allows us to understand what is perceived as normal and what exists outside of the norm through the examination of language and text (Cheek & Porter, 1997). A discourse analysis is intended to unearth the mechanisms that work to form the

discourse. It can also demonstrate how societal norms are established, what purposes they serve, and whose purposes they serve. The analysis finds the norms and highlights that the “truth” was in fact constructed for an historically precise reason (Hook, 2001), resulting in the recognition that truth is produced and not gained transcendently (Mills, 1997). Truth can be seen to originate from a specific set of historical and socio-political circumstances (Hook, 2001). That is to say, how we arrive at a truth is contingent not only upon our own individual positionality, but also the relative positionality of time and space (i.e. what historical period and geographical location we are in). The truth, therefore, reflects not only the positionality of the speaker as the proclaimer of the truth, but highlights the ways that truth was arrived at during that particular era.

Contextualizing the truth in this way allow us to see the ways in which the social norms helped to shape the discourse. Performing a discourse analysis highlights the ways that this conceptualization changed (but did not disappear) throughout different socio-historical periods. A discourse analysis attempts to situate how the norm (or truth) is produced during a specific time, at a particular location, and by particular individuals. The discourse can then be adapted to reflect more socially acceptable norms throughout different historical periods, thereby ensuring that the discourse remains relevant and society is not unduly disrupted.

2.3 Theoretical Foundations of Discourse Analysis: From Structuralism to Poststructuralism

The theoretical underpinnings of discourse analysis are grounded in linguistic, poststructural, and social theory (Cheek, 2004). I will primarily discuss the poststructural underpinnings here, as discourse analysis is concerned with the social and historical textual construction of identity (Crowe, 2005) and these are the aspects I intend to focus on. These features relate back to the central tenets of poststructuralism. As a movement, poststructuralism

sought to interrogate the perceived neutrality of texts by examining the positionality of the author and the socio-historical conditions that it was produced in.

Poststructuralism arose in response to structuralism. Structuralists were concerned with linguistics and believed that language was a system that organized the world in ways that were specific to the culture using it (Caplan, 1989). This had three important implications: i) meaning was fixed; ii) culture could be understood through language by demonstrating what was significant through the specific choice of words, and; iii) that it was the internal structure of the language that provided meaning, not the external referents (Caplan, 1989).

Like structuralism, poststructuralism focuses on the ways that language helps to define and constitute reality (Agger, 1991). Unlike structuralism, however, poststructuralists reject any kind of stability, absolute truth from a singular vantage point, or closed system (Caplan, 1989). Poststructuralists therefore rejected the structuralist constitution of language and meaning as static. At the same time, poststructuralists believed that language is one major way that we as a society reproduce meanings and these meanings are often hidden or unconscious (Belsey, 2002). Poststructuralists therefore often take language as the starting point for their analyses because it is the primary mode of communication between people. This means that language will typically reflect changes in society and its norms. When we think about language in this way, language can be viewed as a repository for social norms and societal beliefs. Definitions become more fluid, with meanings changing over time. That said, words carry the ideas of the past with them. For example, there are a number of words that we no longer use because of their racialized foundations. The words carry their history with them, and this history cannot simply be erased because times have changed.

Poststructuralists moved beyond the idea that texts were fixed in meaning by adding the dimensions of time and space into their analyses. This was accomplished by adding temporal (historical) and spatial (geographical or institutional) axes to their analyses. A poststructural analysis is therefore always local, both temporally and spatially (Miller, 1998). Performing an analysis in this way provides essential context to the normative values inherent within the language (Miller, 1998). What poststructuralism therefore adds to the pantheon of methodologies is that it locates the text temporally, spatially, and individually (via the author), providing the most amount of possible context for any given text. The implications are that we cannot take a text at face value; we must look at the purposes of the text, the possible motivations for the text, and the context that the author was writing in.

Discourse analysis takes this focus on uncovering the underlying ideologies present in any text and focuses on the act of textual representation (Colebrook, 2000). Western thought often posits that there is some kind of truth that can be found in representation (Colebrook, 2000). However, for poststructuralists, writing can be more accurately described as an act that represents the writer, not the subject (Colebrook, 2000). Texts are considered to never be neutral and are instead understood to represent the ideologies of the author. A discourse analysis uses these tenets of poststructuralism to investigate the underlying ideologies present in any text. This is accomplished by examining the positionality of the author, the context, and the proposed purposes of the text. Specifically, discourse analyses attempt to disrupt the notion that the dominant discourse is actually representative of an absolute objective truth. The aim is to unpack the representation in such a way so as to demonstrate the impact the discourse has on its subjects and any benefits it provides to those in control of the discourse.

2.4 Features of the Foucauldian Discourse Analysis

Michel Foucault essentially pioneered his own approach to discourse analysis beginning in the 1960s, refining his techniques with each published work (Mills, 2003). His approach was critical in nature and his scope was immense. Foucault's works span a broad number of subjects, but his main concerns were always centered on the intersections of power, knowledge, and truth (Mills, 1997). These intersections allow us to view discourses as exhibiting "a systematicity of ideas, opinions, concepts, ways of thinking and behaving" (Mills, 1997, p. 15). Foucauldian discourse analysis (FDA) has been described as anti-phenomenological, and the reason for this is that the interior (or nucleus) of the discourse is not sought, but instead it is the forces acting to shape the discourse that are being scrutinized (Hook, 2005). In other words, it is not the subjects of the discourse that we are necessarily looking at, but instead the socio-historical circumstances that made it necessary to conceptualize the subjects in a particular way at that time.

An FDA utilizes only the methods developed by Foucault in its analysis. However, Foucault did not leave any blueprints for conducting an FDA, making them difficult to complete as it is impossible to know if Foucault would have used the exact same approach (Mills, 1997). This statement is particularly true for Foucault since he would often revisit past work and ideas in order to question and re-think them (Mills, 2003). His work pushed all types of boundaries (Mills, 2003) and there was no subject or area of knowledge that was out of bounds for him. As such, Foucauldian discourse analyses are interdisciplinary projects (Mills, 1997). Broad historical knowledge of the time period being discussed is important, as is an intricate knowledge of the subject matter under investigation.

An FDA necessarily begins with a focus on a text. This is a key feature of an FDA, as an FDA situates the discourse temporally and spatially in different historical periods, an act which necessarily involves the use of text. The reason for doing this is to contextualize any "truth

claims” being made. However, the purpose of this textual focus is not to get involved with any type of linguistical analysis, but instead to seek out examples of how the discourse legitimizes certain types of knowledge, and show evidence of materiality (Hook, 2001). In other words, for Foucault, the analysis must move between the text and the real world; there must be evidence of the discourse at work in the real world for the analysis to be complete (Breeze, 2011). In this study, the real-world situation that I am using to explore the concept of caring is the COVID-19 2020 pandemic.

There are numerous methods associated with conducting an FDA, but some of the more recognizable ones are genealogy, a history of the present, problematization, evidence of discontinuity, and exclusions from the discourse (Hook, 2001). Elements of an FDA may be added or subtracted depending on the needs of the author, meaning that the method of conducting an FDA can vary widely (Mills, 1997). Any Foucauldian discourse analysis will not only seek to expose the ideological underpinnings of the dominant discourse but will also highlight some alternative discourses present in society that are actively challenging the dominant discourse.

Foucault did not wish for his work to be perceived as political, but instead seems intent on producing a sense of instability in his readers, leaving them with a sense of questioning their own political position (Mills, 2003). For Foucault, a discourse has no political affiliation, but instead is aligned with a specific ideology, thereby offering a method for an examination of the power and authority that grants agency to the subjects of the discourse (Mills, 1997). It is therefore those who have the power to speak with authority within the discourse that grant agency to the subjects of the discourse (Mills, 1997). This may be perceived as a removal of individual agency. Yet, individuals are never portrayed as powerless victims in Foucault’s

analyses, since the locus of control is never centralized (Mills, 1997). Individuals are able to act either in congruence with societal norms or against them, left to suffer the potential repercussions of these actions. In this way, individual agency is maintained. This helps to explain the presence of alternative discourses, which will represent the views of those outside of the dominant discourse.

2.5 Goals of a Foucauldian Discourse Analysis

The purpose of the FDA is to expose the underlying claims for power and control, rather than to offer some grand, oppositional truth to the dominant discourse (Hook, 2001). An FDA is concerned with asking, “how” and “why” questions regarding behaviors and beliefs by uncovering instances that challenge the dominant discourse (Springer & Clinton, 2015). This alternate vantage point allows the audience to reassess their understandings of power, repression, and progress (Cheek & Porter, 1997). An FDA gives us an understanding where the power is emanating from, how it is reproduced, and how it was formed (Cheek & Porter, 1997). This understanding may allow power to be challenged.

In other words, obtaining the final “truth” is not the ultimate goal of an FDA. In fact, Foucault himself was not concerned with what was true, but rather concerned about how “truths” were produced for specific purposes around specific groups (Mills, 1997). How and what type of knowledge we acquire is linked with power. Where we go to school, what histories we are taught and in what way, and what we are told to read; all of these reflect a different discourse that has been formed and is operative in society (Mills, 1997). An FDA aids the reader in recognizing how ideas (or truth) is formed, who they benefit, and who they are meant to control (Cheek & Porter, 1997). However, Foucault does not so much view the truth as relative as he believes that there are examples of challenges to the dominant discourse that serve to delegitimize it (Hook,

2001). The truth of any given discourse is a perception perpetuated by those who have a vested interest in having this particular truth reproduced within society. What this means in reality is that the representation of truth depends on an individual's personal positionality, beliefs, access to resources, and socio-historical environment.

Demonstrating the impact of the discourse on the body (or the material effects) is an essential aspect of an FDA. For Foucault, this meant moving between the historical examination of the discourse and the evidentiary evidence of it in the real world (Breeze, 2011). In fact, one of the main uses of evidence in an FDA is the effort to demonstrate materiality of the discourse (Hook, 2001). What is absolutely essential in an FDA is a demonstration that the discourse is evidenced by materiality in the world, particularly on the body through training, regulation, and surveillance (Darbyshire & Fleming, 2008; Hook, 2001; Wheatley, 2005).

Therefore, the ultimate goal of the FDA is to offer an alternative perspective to the existing predominant norms by demonstrating how the intersection of power, knowledge, and truth established a discourse that is meant to control a specific population (Mills, 2003). In order to do this, it is essential to show how the discourse impacted the subjects in the real world, specifically materially. The textual focus of an FDA is to not necessarily performed to study what was said and how it was said, but instead to study why it was said and the context that surrounded it (Graham, 2011). Language merely reflects the mechanisms of power at work, making the use of texts inevitable (Buckland, 2016). However, the focus remains very much outside of the text and in the real world.

In the next chapter, I will discuss and define the Foucauldian methods that I have used to conduct this study. I will also discuss how I have demonstrated rigor within the study and also the methods that how I ensured that a complete Foucauldian analysis has been conducted.

Chapter 3: Description of Methods

While Foucault's works on discourse analysis have been hugely influential, he famously never left a blueprint for other scholars to follow for conducting a discourse analysis (Ferreira-Neto, 2018). However, he did leave a number of theoretical ideas and methodologies that are helpful in conducting an FDA. Foucault himself used a variety of tools for conducting his analyses and his methods changed over time (Hook, 2005). Among the tools he created are genealogy, problematization, and a history of the present. Hook (2005) suggests that it is genealogy that best represents a methodology for a historical critique of discourse, as it is through the historical excavation of a discourse that the subjugated voices and thoughts are discovered. While conducting the genealogy, the exploration of historical discontinuities, noting exclusions from the discourse, and seeking examples of discipline within the discourse are the methods he employed to demonstrate the boundaries of the discourse itself and the entities of power who had a vested interest in maintaining the discourse (Hook, 2001).

When these methods are used in conjunction with one another, Foucault stated that these processes demonstrated the "will to truth", which is defined as "the way in which knowledge is put to work, valorized, and distributed" (Hook, 2001, p. 524). A discourse analysis must not only focus on history but must explore the context that allows some ideas to be seen as "true" and others as "not true" (Hook, 2005). Foucault's analyses also focused on examining how the discourse is manifested in the material world; otherwise, the analysis is simply an analysis of text, an oft-lobbied criticism at writers of CDAs (Hook, 2005).

3.1 Problematization

Problematization allows researchers to look critically at something that might have otherwise gone unnoticed. Discourses name, classify, and order objects in the world via the use

of mechanisms such as knowledge, power, exclusion/inclusion, and circulation. (Mills, 1997). In this way, discourse produces the objects that are defined within it (Dreyfus & Rabinow, 1982). Foucault emphasizes this act of recognition. Recognition of objects within the discourse can only be achieved by describing them (Graham, 2011). Once a group is described, it can be recognized. In this way, words and statements can become locatable things, and problematization can occur (Graham, 2011). The underlying assumption of problematization is that the object being examined has some sort of value. Since valuable objects can be viewed as assets, the objects are thereby well-positioned to be a sought-after commodity. This places them at risk for others to seek to control them in some way.

In this study, I problematize the ways that caring might impact the conceptualization and act of nursing itself, both positively and negatively. Problematization is conceptualized in this study through an initial identification of gender norms and relating these norms back to the caring discourse. Problematization was also centered on noting the differences between physicians and nurses, both in the archive and in their respective right to refuse work.

3.2 Genealogy

In order to unearth challenges to the dominant discourse, it is essential to look at historical facts in a different light (Hook, 2005). History needs to be read from a different positionality, typically that of the oppressed or less privileged, in order to obtain a different vantage point for historical events and interpretations of texts (Hook, 2005). Genealogy traces the construction of institutions and practices have been created as a result of specific struggles, events, and exercises of power (Garland, 2014). Genealogy is meant to break down the monolithic hegemony of the historical discourse to highlight the ways in which the discourse has been challenged. The goal of genealogy is not to examine the subject, but to instead examine the

structures that regulate the subject (Hook, 2005). Since discourses are created through struggle, conflict, and marginalization, events outside of the dominant discourse have the power to challenge it (Hook, 2005).

As I stated earlier, the genealogy for this study was conducted from the time period of Florence Nightingale. I will make references to the Victorian era throughout the paper as well, as that is when Nightingale was active as a nurse. This time frame was selected because it is generally referred to as the advent of modern-day nursing (Reverby, 1987; Adams, 2016; Beck, Dossey, & Rushton, 2013; McDonald, 2014). Any attempts to go back further in history would have resulted in a study that would have been very large in size. An identification of the themes and subtexts present in the discourse of caring should be identifiable in the texts available from that time forward. While the archive will focus on Ontario, Canada, the genealogy will also focus on the caring discourse in a North American and European context, as there is enough consistency between the two regions to amalgamate them and the two developed in tandem (Reverby, 1987). I did not attempt to focus on a discourse of caring specific to Ontario, as there not currently enough literature available to support such an attempt, nor is it necessarily likely that the discourse would vary greatly between provinces.

3.3 History of the Present

Foucault called the result of the genealogy a history of the present. The history of the present demonstrates how the seemingly indisputable or seemingly natural current political and social climate of the discourse has actually been historically constructed (Roberts, 2017). The history of the present therefore names the loci of power exerting power on the dominant discourse. The history of the present uses the genealogy to demonstrate how political and social forces have exerted their influences on a given discourse in order to arrive at the situation as it

stands today. The genealogy conducted for this study includes a history of the present; the forces at play and major issues were identified within the context of the discourse of caring, setting the stage for the present state of affairs. It also includes a summary of the contemporary conceptualization of caring in the nursing literature. This will also help to demonstrate how the discourse has changed over time, keeping some of the same essential ideas, only modifying them to become more palatable for a contemporary audience.

3.4 Discontinuity

Following Foucault's method of analysis dictates that history must not be looked at as a seamless, continuous, event. Historical books and commentaries have a tendency to present a unified version of history that is not always so much representative of reality than of a particular point of view (Hook, 2005). This notion of discontinuity (or rupture) seeks to disrupt the discourse by highlighting the ways in which it has been historically challenged, typically by those who also have a vested interest in the discourse. Since discourses are not monolithic, examples of challenges to it may be found in many different streams of knowledge and power from any one of the social, political, and institutional spheres (Frederiksen, Lomborg, & Beedholm, 2015). Any gaps in the discourse of caring will be noted and reasons for these discontinuities will be explored.

3.5 External Exclusions to the Discourse

Discourses do not operate in a vacuum; they are constantly at odds with other discourses that those in power seek to marginalize, de-legitimize, and sometimes even criminalize (Mills, 1997). The discourse dictates what is considered to be "legitimate knowledge" either by accepting only specific methodologies (ex. scientific positivism) or by accepting only specific sources of knowledge. The unspoken aims of any discourse are embedded in the speaker's

positionality and the perceived neutrality of language (Hook, 2001). This serves not only to exclude other forms of knowledge, but actually makes these various knowledges illegitimate (Hook, 2001).

Discourses therefore have formative powers as well as the power to constrain. The discourse operates in such a way that it will exclude that which does not fit in with its predefined norms, establishing an opposition that can be loosely paralleled with the difference between true and false (Hook, 2001). Statements or actions that take place outside of the dominant discourse can be identified as beyond comprehension, illogical, or even mad (Hook, 2011). There are three types of external exclusions to look for when examining a discourse: taboos or rituals, the distinction between madness and reason, and the distinction between truth and falsehoods (Mills, 1997).

3.6 Circulation of the Discourse & Internal Regulation of the Discourse

The discourse remains relevant through circulation (Mills, 1997). Commentary (such as a critique) provides a means for circulation. It also allows commentators to say things that the text does not in fact say (Mills, 2003). Institutions, such as universities, government department, scientific bodies, will work to keep ideas or statements they regard as true in circulation (Mills, 2003). Only statements that are thought to be “legitimate knowledge” will be circulated by those who reproduce and circulate the discourse. Circulation takes place by specific rules; experts are allowed to speak and be heard on subjects they are considered to be experts on (Mills, 2003). Individuals or institutions that are not considered to be experts in that field will not be taken seriously. Experts obtain their credentials by being taught in a specific place, in a specific way, by specific instructors using specific texts, and in a specific time (Mills, 1997). Their voice lends weight to the discourse in circulation, consolidating the discourse and ensuring that other types

of knowledge outside of the discourse is either ignored or discounted. The author, commentaries, the separation of disciplines, and the streamlining of the subject all serve as internal methods of exclusion (Mills, 2003). These mechanisms operate to determine who is authorized to speak, who is not, and in what way the discourse is circulated (Mills, 2003). In a similar vein to external exclusions to the discourse, this study will attempt to determine who has the authority to speak on the association of caring with nurses and look at the ways in which the discourse is circulated.

3.7 Rigor

There is little consensus on how to achieve rigor due to the multiplicity of approaches for conducting a discourse analysis (Nixon & Power, 2007). The methods for establishing rigor in an FDA are exacerbated by the fact that Foucault did not leave behind explicit instructions for how to conduct a discourse analysis. Foucault himself believed that the methodology should be selected based on the specific research problem, individualizing the methodology to each specific problematization (Ferreira-Neto, 2018). Establishing rigor can be further complicated by the fact that any FDA is based on the interpretation of the researcher (Graham, 2011). The interdisciplinary nature of discourse analysis gives the research freedom to pursue their own modes of inquiry, but this can also result in a diversity of results when one subject is looked at by many researchers (Cheek, 2004).

In order to demonstrate rigor in a discourse analysis, Greckhamer and Cilesiz (2014) suggest documenting the decision-making and analytical processes. Foucault himself was meticulous about presenting his methodological choices and provided explicit discussion when he decided to change trajectories (Ferreira-Neto, 2018). In order to accomplish this, Greckhamer and Cilesiz (2014) suggest using a tool they call ‘chronicling’ to provide transparency. This involves detailing the processes and decisions made in analyzing and interpreting the data.

Communicating each aspect of the project and ensuring transparency helps to demonstrate rigor (Greckhamer & Cilesiz, 2014; Nixon & Power, 2007). This transparency establishes trustworthiness between the reader and the researcher, thereby validating the results (Nixon & Power, 2007).

In an FDA, this means that the researcher must detail the logic for moving between text to interpretation (Greckhamer & Cilesiz, 2014). Selections for the archive must also be justified (Cheek, 2004). Using a decision trail that explains the details about the selected methodology are helpful in creating rigor. The details should include details about the texts being analyzed, why they were selected, and what the underlying theoretical framework is (Cheek, 2004). An account of why decisions were made is essential in an FDA, as it is an interpretive process. Crowe (2005) offers the following supplementary questions that help to establish rigor:

1. Is the research question a good fit for DA?
2. Do the texts support the analysis of the research question?
3. Have sufficient resources been considered?
4. Has the interpretive paradigm been explicated? Are all of the processes used in the study congruent with this paradigm?
5. Does the researcher provide a detailed analysis of the data and analysis processes?
6. Are the descriptions adequate for the reader to follow and understand the contexts thoroughly?

I have directly ensured that the above questions were answered throughout the study. I have kept handwritten logs alongside some in a spreadsheet in order to ensure that the decision-making process is recorded in a timely manner. The methodology section has detailed the reasoning behind the selection of an FDA for this particular subject matter.

3.8 Methods of Data Analysis: The Three Axes of Analysis

While I have used Foucault's methods as a general means of organizing this research, his methods were not always clear or straightforwardly described (Ferreira-Neto, 2018). In addition to the Foucauldian approach discussed above, I have added another level of analysis developed by Foucauldian scholars in order to ensure the discourse is being analyzed in line with acceptable procedures. The first level of organization will be accomplished using Foucault's methods as discussed above: genealogy, history of the present, problematization, examples of discontinuities, examples of the circulation of the discourse, and internal/external exclusions to the discourse. I will then refer back to a series of questions formulated by Powers (2013), who formulated these questions based on work done by Rawlinson (1987). I have elected to do so in order to ensure that I have completed the analysis effectively and in line with what Foucault intended. Powers has organized these questions around some key aspects of Foucault's work with discourse. They are genealogy, structure, and power. Utilizing these realms of analysis has helped me to ensure that I have adhered to the general tenets of conducting an FDA.

Answering all of the questions cannot necessarily be completed in a linear manner; therefore, for the purposes of readability, I have responded to the questions throughout this study in areas where they made the most sense. In order to demonstrate completion of the analysis, this table has been replicated in Appendix B and very brief summaries of the associated answers have been inserted. The structure of analysis in an FDA means that the answers to these questions do not need to be drawn solely from the archive but can be analyzed through the supporting documents as well. This summary of responses can also function as a quick reference to the reader. It also serves as a final check to ensure a full analysis has been completed.

Table 1 Powers' (2013) Guide to Conducting an FDA (Questions Only)	
Genealogy	
What other discourses or events provided models or ideas that influenced the functioning of the discourse under analysis?	
What words in the discourse have a linguistic and social history that is significant for assessing the order of the discourse within current power relations?	
What historical context influenced the development of the discourse?	
What physical bodily space was created by being described by the discursive practices of the discourse?	
What surfaces of emergence and conditions of possibility were acknowledged and appropriated by this discourse?	
By what processes did the discourse construct the right to pronounce truth?	
By what processes did the discourse construct the right to pronounce truth in some region of experience?	
What other discourses were affected and how?	
What power struggles or turf battles occurred and what was the outcome?	
In whose interest was the social construction of this discourse?	
Whose interests were ignored and/or rejected?	
Structural Analysis (3 parts)	
Axis of Knowledge (i)	
What is it that guides this discourse?	
What regularities can be discerned?	
What processes differentiate the subjects and objects of the discourse?	
What processes produce the physical space, the meaning, and assumed truth of the discourse?	
What does the discourse do to the resulting subjects?	
How do individual differences, deviations, and complaints emerge in the formation of subject to object?	
What authorities of delimitation exist?	
What are the rules of evidence of the discourse?	
What order governs the multiplicity and diversity of the subjects?	
Axis of Authority (ii)	
What are the rules for who is allowed to speak and who is not?	
How is the discourse preserved, transmitted, disseminated?	
What systems are allowed for education and advancement of members of the discourse?	
How is the right to pronounce truth preserved?	
What speaking positions are available to people within this discourse? What words can be used?	
What speaking positions are not allowed?	

Axis of value (iii)
What social agents are mobilized in order to control the deployment of the discourse and how are they trained?
How does the discourse justify the technologies of power that it constructs for its purposes?
How does the discourse justify suppressing other discourse that challenge its dominance in pronouncing truth?
What justification is provided for the punishment of participants?
What is the justification provided by the discourse for its position as a pronouncer of truth?
Power Analysis
In whose interests is the continuation of the discourse?
Whose autonomy and responsibility are enhanced by this discourse?
Whose autonomy and responsibility are reduced?
What dominations are established, perpetuated, or eliminated?
What sub-discourses of resistance are present within the discourse?
What mechanisms are in place for the systematic co-optation of resistance discourses?
Whose voice is being heard?
Whose voice is being left out?
Do individuals feel constraints against speaking?
Are all voices equally informed?
What power relations exist between this discourse and others?

In order to ensure the integrity of the project, all notes on articles, judgements, postings, and any other potential sources of information were kept either in a journal or computerized into a spreadsheet. A journal detailing the decision-making process and difficulties encountered while performing the discourse analysis were kept. Themes and associations were noted in the same notebook for easy reference.

In the next section, I will discuss terminology. It is essential to understand how Foucault conceptualized a few key terms, as these terms are all interplay with one another. Understanding these terms will help the reader to understand the importance of discourse analysis.

3.9 Terminology

For Foucault, the main targets of a discourse analysis are the triad of power, knowledge, and truth (Buckland, 2016; Cheek & Porter, 1997; Mills, 1997). It is the real effects of this power

that Foucault seeks to expose (Ceci, 2003). Power is linked to knowledge through the production of knowledge, and this knowledge results in “truths”. Knowledge is associated with power via ideology; as those in charge produce knowledge around the subjects of the discourse according to their own ideological outlook, this knowledge is internalized so that it becomes a norm (or truth) (Ceci, 2003). The ideologies and agendas of those with power over the discourse inevitably color the ways in which the discourse establishes itself in terms of what is important, what is not, and what does not belong.

3.10 Power/Knowledge

Power is an abstract concept that Foucault actually uses in a very specific way. For Foucault, power circulates as a set of relations throughout society, disseminated through violence, knowledge, and information (Mills, 2003). Foucault did not see power as a centralized force, but instead conceptualized it as a network of ever-shifting forces (Powers, 2007). Those who have positions of authority in the discourse are able to control what is considered to be true and what is not. For example, leaders of some provincial nursing organizations such as the RNAO or the ONA are more likely to have their voice heard as legitimate than a floor nurse at a regional hospital. Power is a context driven, multi-directional resource that acts more like a web through society than a seat of power and insinuates itself into the discourse through a variety of mechanisms (Mills, 2003). For example, nurses can be disciplined by either their regulatory body, the state/province itself, or their place of employment. All three institutions exercise power, but in different ways and in different circumstances. All three sites of power produce a conceptualization of the individuals they have power over through various mechanisms (such as workshops and literature) by establishing the truths about and the rights of the population that they govern (Powers, 2007). Similarly, other nurses may exercise their power through critique,

bullying, or other forms of establishing knowledge about those they feel need to adhere to norms. For Foucault, power was not isolated to heads of state, but instead permeated society through these various mechanisms (Mills, 2003).

In Foucault's conceptualization, power and knowledge act as a dyad (Rawlinson, 1987). Power and knowledge must be considered together, as the two are reliant on one another. Power is derived through knowledge, and knowledge is collected through procedures, practices, regulations (Rawlinson, 1987). As knowledge is gathered about the subjects of the discourse, the organizations that hold some power are able to justify themselves. For example, the CNO regulates the profession of nursing; it sets the rules for entry to practice, delineates professional responsibilities and standards, and is able to discipline those who break these rules (CNO, May 25, 2017). Power and knowledge are intertwined. The CNO is able to justify its claim to power through its authority over a body of professionals.

3.11 Truth

As discussed earlier, another way of thinking about Foucault's conceptualization of truth is to equate it to societal norms. For Foucault, truth was constructed, in the same way a machine or tool might be (Rawlinson, 1987). Truth is the product of the power/knowledge dyad; truth emerges after the subject has been formed via the processes of power and knowledge (Rawlinson, 1987). A major purpose of an FDA is to expose what is taken-for granted (such as societal norms), to delineate how they are in fact the tools of those who are in power, and to offer an alternative (Cheek & Porter, 1997). Any claims to truth are mitigated by the ideology or intentions underlying the people making that claim (Cheek & Porter, 1997).

So, his conceptualization of truth was not necessarily intended to take aim at claims such as, "The sky is blue". Foucault's target was societal norms and the assumptions that they are

true. Foucault believed that truth was simply a result of socio-political factors, making truth relative to time, space, and socio-political positionality (Colebrook, 2000). This is evidenced by his assertion that discourses are not entirely controlled by those in power; sociohistorical processes and events can also heavily influence and even change a discourse (Cheek, 2004).

3.12 Discipline

Disciplinary power works to create changes in conduct, attitudes, and habits in order to cultivate specific skills or ways of thinking (Holmes & Gastaldo, 2002). Discipline is implemented and maintained via three methods: hierarchical observation, normalization, and examination. Hierarchical observation occurs via scrutiny of behavior, normalization via rules of conduct or other means, and examination via determination of compliance; taken together, they form a regimen of discipline (Springer & Clinton, 2015). Hierarchical observation can be something as simple as a person in a position of power monitoring a nurse who is performing their duties in order to correct. Corrections and/or discipline can occur in real time or at a later time. Normalization is a function of power but does not function through the use of repression (Holmes & Gastaldo, 2002). For example, new nurses are taught through reprimands what constitutes “good” and “bad” behavior in the clinical setting (Frederiksen et al., 2015). Normalization provides order to behavior; behavior is codified and when necessary those in power seek to change it to something that is closer to the prescribed norm (Frederiksen et al., 2015). The final component of discipline is examination. Examination can be formal (written school exams) or less formal (questions posed about a specific process) Constant surveillance produces subjects who self-regulate, acting as if they are always being watched (Wheatley, 2005). Combined, this regimen allows those in power to monitor and punish those who demonstrate noncompliance with the dominant discourse. The subject can be transformed to fit

the discourse by using any or all of the above strategies. Nursing incorporates all three of these components in varying degrees, but certainly includes all three levels of observation.

3.13 The Archive

The archive sets the limits for what can and cannot be said within the discourse via the context and speaker of the statement (Mills, 1997). The speaker (or author) is positioned to be viewed as an authority on the subject, someone who would necessarily know or represent the “truth”. This truth therefore comes with a certain amount of legitimacy that confirms the veracity of what the speaker is saying. The neutrality of the speaker is assumed, thereby adding weight to the veracity of the statement. Foucault argues that the speaker is not neutral but is in fact supported by a wide range of institutional and textual sources (Mills, 2003). As a result of the positionality of the speaker and the supporting institutions (such as educational institutions), this truth is made to seem self-evident (Mills, 1997). However, the unspoken and unseen purpose of this “truth” is to support the hegemony of the dominant discourse.

In the next chapter, I will delve into my analysis of the archive. My search strategy and rationale will be provided. I will also briefly discuss what discourses I identified in the archive and provide a summary table of results.

Chapter 4: Analysis of the Archive

4.1 Search Strategy

The archive for this study was established by conducting a focused search in three of Canada's major newspapers for articles related to nurses and COVID-19. The three newspapers selected to be included in the search are The Toronto Star, The Globe and Mail, and the National Post. Newspapers were selected for this study as they are timely and widely available. They report quickly on changing situations and offer real-time quotes from the individuals and institutions at play. These particular newspapers were selected because they are widely read and easy to obtain.

The search itself was limited to a three-month period, from March 1, 2020 to June 1, 2020, as this correlates roughly with the beginning of the pandemic in Canada. Nexus Uni, a database built specifically for newspaper searches was used to conduct the searches. The search terms included the following terms: nurse*, COVID-19 or coronavirus, work or job, and Ontario. The publication type selected was newspapers, and then delimited to the ones listed above. I selected to limit the return to geography by document to Ontario, Canada. The search strategy and selection of the database was developed in tandem with a librarian employed in the Western University library system. Throughout this process, I provided feedback to my supervisor about the strategy set up with the librarian as well as around the results returned. A separate spreadsheet was created to reflect the themes noted during the review of the articles. A summary of these results is included later in the paper.

There was an original return of 559 articles. The titles and bodies of the articles were initially briefly scanned for anything that was related to issues of safety, work refusal, caring, nursing care, nurses, hospitals, long-term care, and frontline or healthcare workers. These articles

were saved and set aside for a more in-depth review. At this point, duplicates were also identified. Articles were immediately excluded if the nurses included in the article did not practice in Ontario, if the article was not about healthcare in Ontario, if the articles were simply Birth & Death notices, if there were no nurses included or discussed in the article at all, or if the article was simply a summary of the daily news. The body of the articles were then read a second time. Using the technique of “making strange” (Gee, 2014), the articles were read in a critical manner. Story arcs, the use of quotes, and specific language was noted. The articles were also evaluated in relation to the research question, based on the methods of analysis from Foucault and Powers (2013) (Kuper, Whitehead, & Hodges, 2013). Any themes that I identified were noted and placed on an Excel spreadsheet. Important quotes and details were also initially placed onto the same spreadsheet.

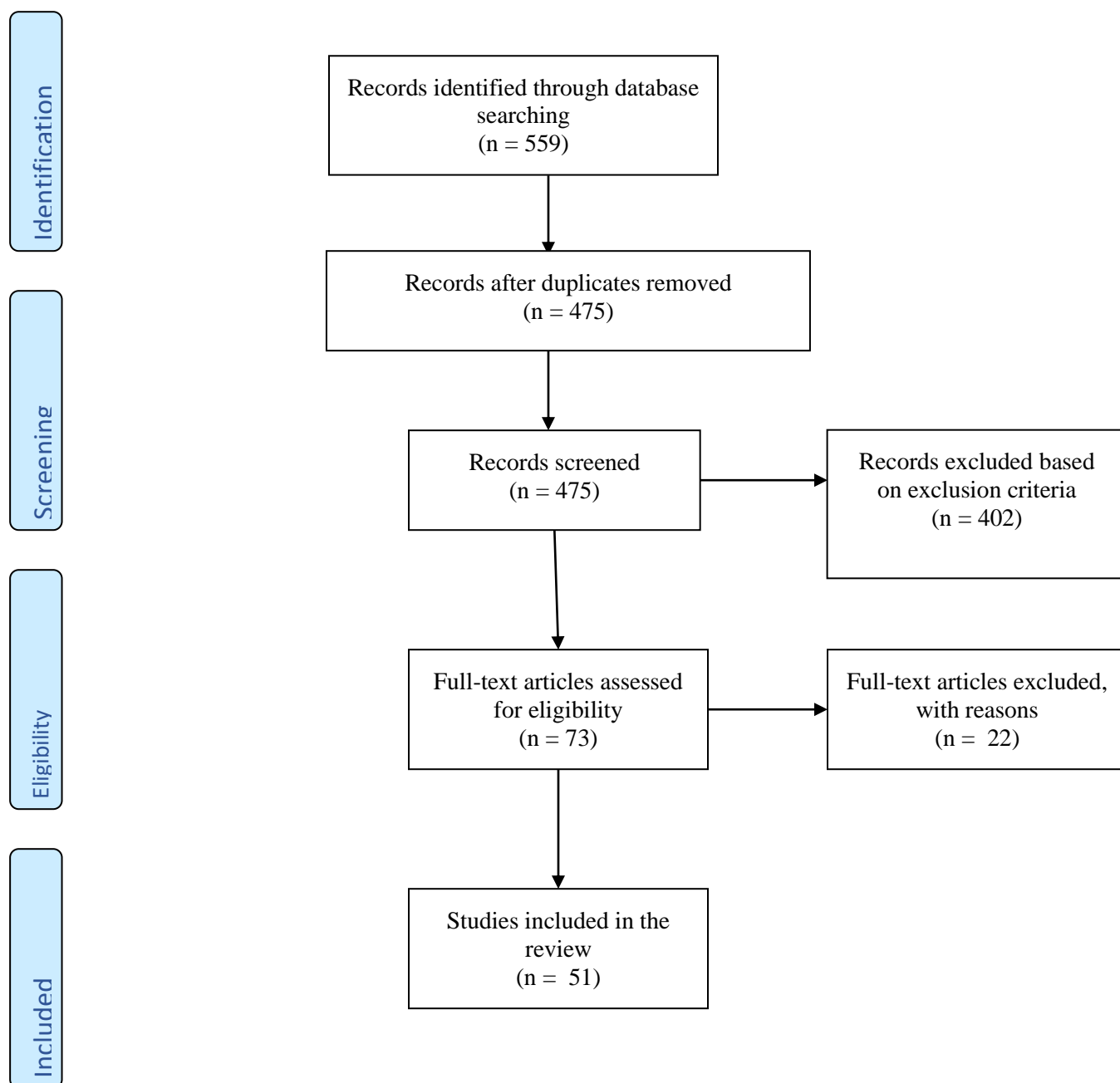
The articles were then read a third and fourth time through, two and three weeks later respectively, in order to ensure consistency of approach and also to re-analyse the archive for additional themes or discourses. There is a process of moving back and forth between text and analysis numerous times that informs this particular process of the analysis (Kuper, Whitehead, & Hodges, 2013). At this time, some further themes were noted, such as the presence of the unnamed nurse and numerous instances where nurses were depicted performing acts of kindness. I also made the determination at this time that any clinician that was the head of a large organization such as the Ontario Medical Association or RNAO would not be included in the tally of individuals being critical of the government response to the pandemic. Their position of power most likely removed any fears they may have had related to publicly criticizing the government response to the pandemic, unlike many other nurses present in the archive.

4.2 Results from the Archive

Most articles that talked about nurses during COVID-19 were focused on the issues surrounding personal protective equipment (PPE) and safety. For much of March and April, nurses reported actively being denied the use of N95s when dealing with a COVID-19 positive patient (Arthur, March 30, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*; DiManno, March 27, 2020, *The Toronto Star*; Ferguson, April 2, 2020, *The Toronto Star*; Li, April 24, 2020, *The Toronto Star*; McLean & Welsh, April 18, 2020, *The Toronto Star*; National Post, April 1 (i), 2020; National Post, April 1(ii), 2020; National Post, May 16, 2020; Parks, Bain, & Jewell, May 18, 2020, *The Toronto Star*; & The Toronto Star, April 20, 2020). Even when PPE was available, staff in one facility were told not to wear surgical masks in the halls as it might scare the residents of a long-term care home (LTCH) (McLean & Welsh, April 18, 2020, *The Toronto Star*).

A few articles suggested that nurses are generally given less PPE than physicians, in spite of the fact that they generally have more contact with patients than physicians (Arthur, 2020 March 30, *The Toronto Star*; DiManno, April 8, 2020, *The Toronto Star*; The Toronto Star, April 20, 2020). One nurse reported that she was told to limit the number of patients the physician sees face to face (The Toronto Star, April 20, 2020). In addition, physicians stated that they had been given advice on how to manage patients with COVID-19 remotely, including tips on how to estimate blood oxygenation levels visually via video or monitor all patients virtually (Yang & Ogilvie, April 4, 2020, *The Toronto Star*). In another article, a physician praised nurses and said that they are brave, since they were the ones that were performing the swabbing (DiManno, 2020 April 8, *The Toronto Star*). One physician noted that nurses took off and put back on the same PPE many more times than a physician, since they are always going in and out of patient rooms (DiManno, March 27, 2020, *The Toronto Star*). This continued donning and doffing of PPE

Figure 1. Flow Chart of Search Results



(Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009).

could potentially place nurses at even greater risk of contracting the disease, because they would be handling an extremely contaminated pieces of PPE multiple times throughout the day. PPE is meant to be used once and then discarded (Public Health Ontario, April 4, 2020). Many unnamed nurses were reported to have contacted *The Toronto Star* in order to express their frustration and fear over a lack of PPE (Ferguson, 2020 April 2, *The Toronto Star*).

In the early days of the outbreak (i.e. March & April), infectious disease experts (who are typically MDs), advised the province to stop requiring airborne precautions for the disease, not only because the scientific evidence pointed towards droplet transmission, but also as a means to conserve sparse resources (Cribb, May 4, 2020, *The Toronto Star*; The Toronto Star, April 20, 2020; Ward, March 15, 2020, *The Toronto Star*; Weeks, 2020, March 11, The Globe and Mail; Weeks, April 3, 2020, *The Globe and Mail*). Physicians specializing in infectious diseases made it clear that allowing healthcare workers access to N95s when the science did not support their use was an unnecessary expenditure (at best) and a waste of resources (at worst), particularly when the supply chain is questionable (Cribb, 2020, May 4, *The Toronto Star*; Ward, 2020 March 15, *The Toronto Star*; Weeks, 2020, March 11, *The Globe and Mail*). Dr. Gary Garber, an infectious disease specialist at Public Health Ontario, stated that wearing N95s all day is uncomfortable, which leads to healthcare workers touching the masks, thereby negating the effects of the mask (Cribb, May 4, 2020, *The Toronto Star*). Other physicians were also quoted as saying that extra levels of precaution cannot be accommodated during a shortage (Weeks, April 3, 2020, *The Globe and Mail*). The implication of statements such as these is that the actual supply supersedes a nurse's desire to maintain their own safety when the science is still evolving around an issue. There was some speculation around whether or not the policy of Public Health Ontario to downgrade from requiring the use of N95s was based on scientific fact or a supply

issue (Arthur, March 30, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*; The Toronto Star, April 20, 2020; The Toronto Star, May 16, 2020).

One of the reasons listed for reducing access to N95s was that it would leave future healthcare workers who perform any kind of aerosolized procedure at risk for disease (Ward, March 15, 2020, *The Toronto Star*; Weeks, March 11, 2020, *The Globe and Mail*; Weeks, April 3, 2020, *The Globe and Mail*). The stated goal was that the healthcare facilities needed to ensure that enough N95s remained for the medical procedures that may or may not happen in the future. The implication of this behavior was that the healthcare facilities were saving N95s for procedures that might not even happen at the expense of the healthcare workers who felt that they needed them now. The supply chain was of course one factor in the decision-making, but perhaps there were other, unspoken assumptions underlying these actions, such as the perceived value or importance of nurses and physicians.

The statistics on the number of healthcare workers infected may help to support the theory that healthcare workers were being sacrificed. Michael Hurley, vice-president of the Canadian Union of Public Employees in Ontario (representing practical nurses, personal support workers, hospital cleaners and other health care workers) stated that the rise in cases among health care workers demonstrated that the PPE alone is not sufficient to protect workers (Donovan, April 29, 2020, *The Toronto Star*). By April 29, 14% of COVID-19 cases were among health care workers, a higher infection rate than found in healthcare workers in China, which was found to be 3.8% (Donovan, April 29, 2020, *The Toronto Star*). Unfortunately, the Health Ministry of Ontario does not keep track of the specific job type for each healthcare worker infected, so there is no breakdown of occupations in the number of healthcare workers being infected (Donovan, April 29, 2020, *The Toronto Star*). However, by May 14, 17.5% of all

cases of COVID-19 in the province of Ontario were healthcare staff (Schwartz et al., 2020). Of this 17.5%, 20.2% were nurses, and 2.3% were physicians (Schwartz et al., 2020). The remainder remained unclassified, but all worked within healthcare in some capacity (Schwartz et al., 2020). The difference between the number of nurses infected versus the number of physicians should provide a clue around who was more likely to get infected, and also who might be in need of some extra protection or education.

In response to this, public health care leaders pointed out that just because a health care worker has the virus, it does not necessarily indicate that they got the infection at the hospital (Donovan, April 29, 2020, *The Toronto Star*). These articles highlighted the ongoing exchanges between nurses and medical experts over where the blame is to be placed around increased infection rates. Nurses contend they required more PPE, but experts disagreed that this was necessarily the case. Science, not safety, was given the priority.

As a result of the fact that masks were actively being withheld from nursing staff, some nurses reported a sense of mistrust developing between nursing staff and administrative management (McKinley, April 20, 2020, *The Toronto Star*; *The Toronto Star*, April 20, 2020). A nurse who requested not to be named stated that she had heard that managers were telling staff that, “This is what you signed up for” in response to a request for PPE (Cribb, May 4, 2020, *The Toronto Star*). One nurse stated that she felt that their entire worth had been reduced to two masks and a brown paper bag (Ferguson, April 2, 2020, *The Toronto Star*). It was also reported that staff who do not belong to unions were in fear of being fired for work refusals or complaining (*The Toronto Star*, April 28, 2020).

In response to the fact that PPE was being withheld, work refusals occurred in a “profession that never does it” (National Post, April 1(i), 2020). In spite of this, there were

reports that employers were overheard stating that they will charge and report those who refuse work (National Post, April 1(i), 2020), perhaps in an attempt to exploit workers who perceive it to be their duty to help, who did not want to be reported to the CNO, or who felt that it was necessary to hold onto their jobs, no matter what the cost.

By mid-April, tensions around access to masks deteriorated to the point that the Ontario Nurses' Association went to court to force hospitals to provide masks to their employees (McLean & Welsh, April 18, 2020, *The Toronto Star*). The ONA had initially tried to get the province to intervene but stated that they did not receive any meaningful intervention from the province (McLean & Welsh, April 18, 2020, *The Toronto Star*). Once again, it is possible to read this measure to save masks as a subtle judgment by those in power about who is more valued: physicians or nurses. Physicians absolutely perform more aerosolized procedures than nurses, although they are often assisted by nurses. This places them at higher risk of contracting disease. However, nurses tend to have more contact with patients, also increasing the risk of contracting disease. When these actions are evaluated at in this way, the unstated assumption appears to be that nurses are worth the sacrifice.

While an agreement was worked out between the unions and the province in Alberta and Ontario regarding supplying nurses within the hospital environment with N95s (Weeks, April 3, 2020, *The Globe and Mail*), this agreement left out the issue of LTCH. A subsequent lawsuit was brought by the ONA against four LTCH over access to PPE. What was most interesting about this lawsuit was the argument brought forward by the representatives of four long term care facilities in Ontario to justify limiting access to PPE. The long-term care facility representatives argued that providing their staff with N95s may result in a province wide shortage (National Post, 2020, May 16). The representatives of the long-term care home were attempting to bargain

the health of actual nurses against a theoretical future shortage across the province. Again, the implication in their argument was that nurses should be prepared to sacrifice themselves in the short-term against a theoretical long-term. The judge disagreed with their argument and the motion to supply masks was passed.

Another theme noted during the analysis of the archive is the propensity to write “feel-good” stories about nurses. For example, there was the articles about two nurses who singlehandedly combatted an outbreak at a long-term care facility, dropping everything to return to work (Welsh, April 5, 2020, *The Toronto Star*). No mention is made of any personal cost to the nurses for this action. Another article about nurses being very responsive to returning to the workforce to help during the COVID-19 pandemic paints a picture of individuals who are ready to do whatever it takes to protect the public (National Post, March 17, 2020). These articles conveyed a sense of confidence in the nursing profession, while implying that the general public would have nurses available to care for them if they did get sick.

Other articles described nurses speaking very lovingly of those that they are caring for in LTCH, and expressing discomfort with the ways in which the bodies are treated if the individual dies from COVID-19, as there are special infection control procedures put in place for those who die as a result of COVID-19 (Welsh, April 30, 2020, *The Toronto Star*). Nurses were described as holding hands of those who died, and a family member notes the staff’s love and concern for residents (DiManno, April 2, 2020, *The Toronto Star*; Grant & Mahoney, May 1, 2020, *The Globe and Mail*; Welsh, April 30, 2020, *The Toronto Star*). One story describes a nurse as “gently” putting a thermometer in the ear of a mourner at a funeral (Orms, March 22, 2020, *The Toronto Star*). Another article tells the story of a nurse worked at a long-term care home, finishing her shift in spite of the fact that she was symptomatic, because she knew there was no

one else to care for these people (Li, April 24, 2020, *The Toronto Star*). There was no description of how the disease might affect her personally, or whether she had any health conditions or family at home to care for; it was simply a testament to this nurse's desire to care for other people. There was the story of the nurse who bonded so well with one of her COVID-19 patients that they are now friends, hanging out and spending time with one another (Contenta, April 18, 2020, *The Toronto Star*). This particular nurse stressed the importance of the human aspect of nursing (Contenta, April 18, 2020, *The Toronto Star*). Another article from the archive describes how a nurse used to hug patients all the time prior to the outbreak, but now she has to stop herself (National Post, April 4, 2020). A nurse of 33 years describes how she spent time with a co-worker who was infected with COVID-19, holding their hand, praying with him (Ogilvie, April 14, 2020, *The Toronto Star*). The purpose of these stories is unclear, other than the fact that they stress the perceived caring aspect of nursing.

The presence of an "unnamed nurse" was a feature of many articles. In this instance, I do not mean in the sense that the nurse declined to be named, but rather the tendency to refer to nurses in articles by their profession (i.e., "the nurse"), instead of by their name or some other descriptive. Many articles simply referred to "the nurse" or "a nurse", without bothering to give them any physical description or name (Arthur, March 30, 2020, *The Toronto Star*; Arthur, April 2, 2020, *The Toronto Star*; Arthur, May 18, 2020, *The Toronto Star*; DiManno, April 1, 2020, *The Toronto Star*; DiManno, April 2, 2020, *The Toronto Star*; DiManno, May 9, 2020, *The Toronto Star*; Grant & Mahoney, May 1, 2020, *The Globe and Mail*; McKinley, April 20, 2020, *The Toronto Star*; National Post, May 26, 2020; The Toronto Star, April 20, 2020; Welsh, April 5, 2020, *The Toronto Star*). One article from the National Post did provide a physical description, but all three nurses were dressed in the exact same uniforms, lending a somewhat

surreal quality to the description, as nurses' uniforms can vary quite widely (National Post, April 28, 2020).

This trend of unnamed nurses was particularly prevalent throughout the “feel-good” stories. For instance, there was a description of an unnamed nurse telling a family member their loved one had died over the phone (Arthur, May 18, 2020, *The Toronto Star*). The unnamed nurse describes the importance of listening in such a situation. One unnamed nurse is described as providing personal care to a dying patient (brushing hair, washing her skin) (DiManno, April 2, 2020, *The Toronto Star*). Yet another unnamed nurse later holds the phone to the patient's ear so the family could speak with her (DiManno, April 2, 2020, *The Toronto Star*). The family expresses their gratitude that the nurse is there, without explicitly naming the nurse. References of this type almost convey a sense that the nurse is simply another object in the room, faceless and nameless. When taken together, it can give the reader the impression that the nurses are interchangeable and object-like, unimportant enough to merit being given a name.

The other place where unnamed nurses appeared was when nurses were being critical of either their healthcare organization or the government's response to the pandemic (Arthur, April 2, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*; KiManno, April 1, 2020, *The Toronto Star*; Ferguson, April 2, 2020 *The Toronto Star*; Li, April 24, 2020 *The Toronto Star*; Warren, April 11, 2020, *The Toronto Star*). Very often, the nurse asked that their name be withheld, although this was not always indicated in the article, making it difficult to know for sure. I should note here that if a person stated that they did not wish to be named because they were not authorized to speak, I erred on the side of caution, and did not consider that their desire not to be named was the result of working within a punitive workplace. If the workplace was identified as punitive or the individual stated that they feared retribution, then

that was included in the final tally of those who were unnamed at their own request.

Additionally, nurses or physicians who are employed as the head of large representative organizations (such as the RNAO, Ontario Nursing Association, or Canadian Medical Association) were not included in the tally of named nurses or physicians who criticized organizations. This is because they have the full weight of a relatively large organization behind them, and do not have the same concerns as floor staff. The leaders of those organizations were typically named in the articles.

This fear of retribution was a common theme throughout many of the articles. Some nurses stated that they felt that they were being asked to sacrifice everything in return for two masks a day and were scared to talk due to the perceived punitive nature of their work environments (Arthur, March 30, 2020, *The Toronto Star*). It was rumored that one nurse who posted a video clip to her Facebook account asking the public for PPE donations was going to be fired as a result of the video (DiManno, April 1, 2020, *The Toronto Star*). The article did not name the nurse who posted the video nor was I able to find any follow up information regarding the nurse. The same newspaper put in a request to the hospital to interview front line workers, and the hospital declined to allow it (DiManno, 2020 April 1, *The Toronto Star*). One unnamed nurse gave a reporter from The Toronto Star internal memos from her hospital regarding the re-use of N95 masks (Warren, April 11, 2020, *The Toronto Star*), presumably in an effort to make the knowledge public.

Overall, these articles give the impression that nurses are not being allowed to speak openly. In addition, the overall impression generated by the articles is that it is the healthcare facility that controls the narrative around who is and who is not allowed to speak. This is

accomplished through fear of retribution within the workplace and threats to report nurse's behavior to the regulatory body.

This situation is doubly problematic due to the advice given to nurses by the CNO regarding self-advocacy. Rather than giving nurses outright permission to refuse work that is potentially unsafe, the CNO suggests advocating for a quality work environment (CNO, 2017). The CNO states that work refusal is an ethical dilemma, requiring careful consideration on behalf of the nurse. Based on the evidence gathered from the archive, it would seem that many nurses feel that they can only advocate for themselves when they omit their name. The CNO has placed nurses in a position that essentially forces them to continue to work and then asks them to improve workplace conflicts through advocacy. Healthcare facilities take full advantage of what is essentially a loophole, silencing nurses who want to advocate for improved working conditions by threatening to fire or report them.

That said, there were some examples in the archive of nurses who were not afraid of speaking out and using their own names to criticize the leadership of healthcare facilities. Parks, Bain, & Jewell, (May 18, 2020, *The Toronto Star*), three nurses from Ontario, state that things have never been grimmer. These three nurses nursed through the SARS crisis of 2003. They state that at this time, they are afraid of dying or of infecting their families. Another nurse wrote a poem about her feelings and posted it to her personal Facebook account (Holmyard, May 15, 2020, *The Toronto Star*). The poem spoke to the two mask/day policy, the fear associated with working in these conditions, and the uncertainty about working in new teams with unknown team members after redeployment authorized by the government. There has been no news on whether or not this nurse was threatened with any forms of discipline for expressing her

opinions, as there was with the nurse used in the earlier example (DiManno, April 1, 2020, *The Toronto Star*).

In contrast, physicians were more likely to attach their name to criticism. Physicians often had their name published when quoted, even if they were being critical of their administration or the handling of the COVID-19 response by the government (See Cribb, May 4, 2020, *The Toronto Star*; Grant & Mahoney, May 1, 2020, *The Globe and Mail*; Riches, April 11, 2020, *National Post*; The Toronto Star, May 16, 2020; Weeks, March 11, 2020, *The Globe and Mail*; Yang & Allen, March 21, 2020, *The Toronto Star*). The proportion of unnamed nurses and unnamed physicians criticizing the response to COVID-19 was found to be 5:3. The proportion of named nurses to named physicians criticizing the response was 2:6. This finding supports the findings of Gordon and Nelson (2006), who assert that journalists turn to physicians, not nurses, for health care news.

For example, one physician sent out an email to Ontario's medical officers of health, asking them to temporarily close businesses in order to prepare for what was coming (Yang & Allen, March 21, 2020, *The Toronto Star*). A director of care in a hospital criticized health officials for not handling the outbreak better and not admitting that community spread was occurring (Yang & Allen, March 21, 2020, *The Toronto Star*). Another physician was given credit twice in two separate newspapers for calling attention to an outbreak at a local LTCH (Grant & Mahoney, May 1, 2020, *The Globe and Mail*; Riches, April 11, 2020, *National Post*). The physician in question was credited for drawing attention to it over social media. That same physician was given credit throughout the article, which seems odd since the home itself was likely staffed by nurses and PSWs, the fact that the physician was not even an employee of the home, and the fact that he worked at a hospital 30 kilometers from the home. What is not

mentioned in the article are the opinions of the nurses and PSWs who work at that home, who more than likely were very aware of the outbreak before anyone else. This might serve to underscore one impression that was given when going through the archive: when nurses use their own names to draw attention to situations, there is a chance they may be either threatened, disciplined, or fired.

Nurses were often portrayed as handling emotional work, whereas physicians were depicted as conducting research, making decisions, and performing medical procedures. In one article in the archive, intensive care unit (ICU) nurses were named explicitly as the “emotional conduits” between families and the COVID-19 patients and one of these same nurses describes the job as emotionally exhausting (Arthur, May 18, 2020, *The Toronto Star*). This is a somewhat surprising characterization of ICU nurses, as they are some of the most highly technically trained nurses in the field of nursing. Their knowledge around medical procedures and technical knowledge is generally incredibly high. Here, however, they are being reduced to emotional conduits. There is only one instance where a nurse (who is given a name) is described performing something other than a “caring” duty. The nurse is described as monitoring vital signs, the ventilator, medications, IV, as well as ensuring the patient’s comfort (Ogilvie, April 14, 2020, *The Toronto Star*).

Physicians, on the other hand, were more often depicted as performing medical procedures. Physicians were described as intubating patients as soon as they get to work, with little mention made of their home life (Yang & Ogilvie, April 7, 2020, *The Toronto Star*). Doctors were also described as checking scientific literature as often as possible, as well as provincial websites outlining safe procedures for intubation and guidance on who to admit and who to send home (Yang & Ogilvie, April 7, 2020, *The Toronto Star*). One physician was

described as working studiously away at interpreting scientific literature into policy at the hospital, with no references to patient care or interaction (National Post, April 4, 2020). One physician noted that there is an online site dedicated to help guide healthcare workers at the bedside, perhaps unaware that many health care facilities prohibit nurses from having their cell phones on the floor (Yang & Ogilvie, April 7, 2020, *The Toronto Star*). Physicians were described explaining how mechanical ventilation works, something that any nurse who works in an intensive care unit could certainly explain (Yang & Ogilvie, April 7, 2020, *The Toronto Star*). A thoracic surgeon was described as being interviewed post-surgery, and was then described as highly skilled (DiManno, April 8, 2020, *The Toronto Star*). In sum, the contrast between nurses and physicians is dramatic, with the physician portrayed as the individual researching and implementing scientific activity, and nurses as comforting patients or providing emotional support.

There is a stark contrast in the archive between the depictions of physicians and nurses, in spite of the fact that, in many ways, their skill sets should overlap. Physicians often appeared as almost detached from the caring process or from patient care altogether. Nurses were depicted as being absent from the research and scientific processes involved in medical care, when many nurses are very familiar with research processes and the scientific process. In fact, there are jobs to be found as a nurse researcher and the CNO states that keeping up to date with current research should be part of a sound nursing practice (CNO, 2018).

In keeping with this theme of caring, nurses reported being scared about contracting the disease and about bringing it home to their families (Arthur, March 30, 2020, *The Toronto Star*; Ferguson, April 2, 2020, *The Toronto Star*; Parks, Bain, & Jewell, May 18, 2020, *The Toronto Star*; *The Toronto Star*, April 20, 2020; Ward, March 15, 2020, *The Toronto Star*; Welsh, April

9, 2020, *The Toronto Star*). There was one instance where a physician spoke outright about her concerns for her family, but it is possible that the key word in that observation is “her” (McKinley, April 20, 2020, *The Toronto Star*). One physician does admit he felt fear prior to going to work (Yang & Ogilvie, April 7, 2020). These particular findings highlight the fact that discussions around feelings that can often be found within the nursing discourse but tends to be less focused upon when physicians are discussed.

4.3 Discourses identified in the Archive

I identified three discourses circulating in the media accounts, which I will touch upon briefly in in this section. These include: public health, war, and sacrifice.

Public Health

The debate over PPE was essentially a debate over who controlled decisions related to public health. As evidenced by the archive, it was physicians and infectious disease specialists who helped to guide the decisions and had the authority to speak out and make decisions regarding PPE. It was the physicians who mandated what was safe, with no clear reference to what nurses thought. It is interesting to note that it is now physicians who are most often interviewed as authorities of infectious disease, as this erases nursing’s important role in the controlling the chain of infection within a healthcare facility. In addition, Florence Nightingale worked very hard on basing her treatment decision on the epidemiology and statistics (McDonald, 2010; Winkelstein, 2009), and these are two important components of infectious disease control.

War

Perhaps the most readily identifiable discourse noted in the archive was the one that equated fighting COVID-19 with war. In fact, ‘war’ was identified a total of 9 times out of the 51

articles included in the archive (Arthur, March 30, 2020, *The Toronto Star*; Arthur, April 2, 2020, *The Toronto Star*; DiManno, April 1, 2020, *The Toronto Star*; DiManno, April 14, 2020, *The Toronto Star*; Donovan, April 7, 2020, *The Toronto Star*; Grant & Mahoney, March 30, 2020, *The Globe and Mail*; National Post, 2020 April 1 (i); National Post, May 1, 2020; Yang & Allen, March 21, 2020 *The Toronto Star*). ‘Hero’ was used in relations to all healthcare workers a total of 6 times (Arthur, March 30, 2020, *The Toronto Star*; Arthur, April 2, 2020, *The Toronto Star*; Arthur, May 18, 2020, *The Toronto Star*; Holmyard, May 15, 2020, *The Toronto Star*; Riches, April 11, 2020, *National Post*; Welsh, April 5, 2020, *The Toronto Star*;). The word ‘sacrifice’ appeared 2 times in direct reference to nurses (Monsebraaten, April 6, 2020, *The Toronto Star*; National Post, May 16, 2020).

Sacrifice

Sacrifice makes sense in the discourse of war as it can easily be related by most people back to the imagery of soldiers sacrificing themselves during wartime for their country. The mention of sacrifice is also notable because it can also be found within the discourse of caring. In the Victorian era, the discourse of caring included the idea that self-sacrifice and altruism were desirable traits in a nurse (Dahlke & Wall, 2017; Reverby, 1987; Roberts & Group, 1995a). This ideal goes back to the Victorian Era. As discussed in the genealogy section, caring was an essential part of being a nurse during the Victorian era and stemmed from the assumption that it was a woman’s duty to care (Anthony & Landeen, 2009; Dahlke & Wall, 2017; Reverby, 1987). Nurses, working within a profession that at the time was constituted solely of women, were expected to care. At that time, the belief was that nurses did not need to be taught how to care, as caring was an innate trait of the female gender (Anthony & Landeen, 2009). The concept of self-

sacrifice can also be found in the discourse of motherhood, a discourse that can also be linked to the nursing profession (Dahlke & Wall, 2017; Reverby, 1987; Van Nistelrooij & Leget, 2017).

4.4 Discontinuity and Exclusions to the Discourse

There are many examples of discontinuity, both within and outside of the archive. Nurses who harm, for example, are a major discontinuity within the discourse as a whole. Some of the more extreme examples of discontinuity are nurses who harm. Beatrice Yorker (2018) was able to identify 131 healthcare workers who were charged with murder between the years of 1970 and 2018 in 25 countries. Yorker's findings excluded murders by healthcare workers that were committed outside of the healthcare setting, murders that had motives such as revenge or inheritance, and acts of gross negligence, meaning that all of these murders were essentially the murder of strangers (Yorker, 2018). Of the 131 that were prosecuted, 90 were convicted. Of the 131, a total of 18 cases either had the charges dropped, had the defendant found mentally unfit to stand trial, four were still awaiting trial, and four of the results were still pending (Yorker, 2018). In one case, the defendant committed suicide prior to the trial's commencement. Yorker's results did not include any cases that were not adjudicated. Yorker's conclusion is that murder committed by healthcare workers is certainly not the result of "isolated instances", but instead suggests that they are more indicative of a "phenomenon" (Yorker, 2018, pp. 3-4). Of the 131 prosecuted, 88 were nurses (Yorker, 2018). Yorker further writes that detection of these healthcare worker deaths is quite difficult, as death is often expected in many of the cases, and the method most used is a diversion of injectable medication (specifically, insulin). She also blames a lack of reporting mechanisms for suspicious behavior, and inadequate background checks on new hires. In fact, Yorker found that when other nurses spoke to the administration about their concerns about another nurse, the reporting nurse was often, "harassed, fired, or

otherwise silenced and disciplined in a retaliatory way” (p. 20). The question here, of course, is if caring is the essence of nursing how can a nurse both be caring and harmful?

Yorker was asked to testify at the trial of Elizabeth Wettlaufer. Wettlaufer, a London, Ontario based nurse who worked in Long-Term Care homes (LTCH) for over a decade, was recently convicted of murder. Wettlaufer in fact confessed to a number of people about her actions over the years. (Dubinksi, July 31, 2019). Wettlaufer had previously confessed to friends, a former partner, and a pastor about her actions in 2011 and then again in 2014 (Dubinski, August 11, 2018). In spite of her multiple confessions, Wettlaufer was not reported and continued to practice as a nurse until 2016. It was not until one of her confessions was actually taken seriously that she was caught (Breen, July 31, 2019). At the nursing disciplinary hearing for Wettlaufer, the CNO found that Wettlaufer had acted in a disgraceful, dishonorable, and unprofessional manner (CNO, July 25, 2017). Wettlaufer had already given up her membership with the CNO, but at the disciplinary hearing, the CNO officially revoked it. Her actions were described as heinous by the disciplinary panel (CNO, July 25, 2017). Nurses who harm are not only an example of a discontinuity, but also an example of an external exclusion. Nurses who harm are not addressed by the discourse of caring. Nurses who harm are not only examples of discontinuities, but they are also used as an external exclusion to the discourse, as they are often identified as insane by others and discussing them in the nursing context may be considered to be a taboo.

There are further, less egregious examples of “non-caring” nurses. The CNO publishes a summary judgment of each case that they try monthly against nurses at their headquarters in Toronto, Ontario. In the month of June 2020, nine cases were published in their monthly newsletter, *The Standard*. One member was found guilty of making racial slurs, failing to

comply with the physician's orders, failing to provide adequate care to a number of patients, and leaving early without giving report (CNO, June 2020). Another member was found guilty of yelling at a patient and pushing them down (CNO, June 2020). Another was found guilty of having a personal relationship with a patient and of posting patient information on social media (CNO, June 2020). Examples of non-caring nurses can be found throughout the profession, challenging the dominance of the caring discourse.

Discontinuity of the discourse was also exemplified in the genealogy. In the first half of the 20th century, there was little reference to caring in the nursing texts and literature. As I discussed earlier, this is likely because caring was an assumed attribute of the nurse. However, the absence of caring in the literature at that time perhaps suggests that caring is not as central to the nursing professional as it is often assumed to be. Otherwise, it seems probable that there would be a focus on it, at some point, in the literature.

Discontinuity in the archive is demonstrated through the objection of nurses to being provided PPE that they deemed to be unacceptable. Nurses continued to object to working without what they warranted was appropriate PPE. Nurses objected so much that they walked off the job. One nurse stated that most nurses she knew would not work if they were not provided appropriate PPE (Arthur, April 2, 2020, *The Toronto Star*). In spite of the fact that the discourse of caring emphasizes self-sacrifice, nurses instead chose to emphasize their own safety. This push for safety by nurses was met with much resistance, by their employers and experts. Nurses prioritized their safety but were expected to be self-sacrificial. This situation was complicated by the fact that nurses had most venues of complaint and refusal of work taken away from them, virtually forcing them into what many considered to be an untenable position.

4.5 Examples of Discipline

The CNO chairs a disciplinary committee that can impose punishment on nurses within Ontario. According to the CNO, the purpose of the disciplinary committee is to educate nurses and inform the public on what constitutes incompetence and on professional misconduct (CNO, 2019a). Nurses who have been reported to the CNO (either by a member of the public or by a professional associate) will be asked to attend a tribunal whereby the circumstances of the alleged offences will be discussed. The names and qualifications of the individuals that sit on the panel are not generally disclosed to the general public unless the full result of the disciplinary decision has been published. This serves as an example of the many ways that power is diffused throughout the discourse. Nurses can be disciplined either from their institution, the CNO, or even legally by the province as a result of their action or inaction. This displays the diffusion of power that Foucault discusses, in the sense that power does not emanate from one source, but instead is directed at the subject from multiple angles.

The CNO tribunal also functions as a means of disciplining the subjects of the discourse. As discussed earlier, disciplinary power, in a Foucauldian sense, operates to normalize, examine, and observe the behaviors of the subjects of the discourse (Springer & Clinton, 2015). The CNO disciplinary board does not only reprimand and dole out punishment to those who commit bodily harm; it also regulates administrative errors and personal relationships. The CNO governs documentation, administration, and even the behavior of nurses, by insisting that nurses follow their Code of Conduct (CNO, 2019b). This process also acts as a means of gathering knowledge about the subjects of the discourse, linking it to power and truth in the Foucauldian sense.

In the evidence gathered in the archive, there were a number of instances where nurses were threatened with disciplinary action or retribution within the workplace should they choose

not to comply with the order to work with surgical masks only (Arthur, March 30, 2020, *The Toronto Star*; Arthur, May 18, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*; DiManno, April 1, 2020, *The Toronto Star*; Donovan, April 7, 2020, *The Toronto Star*; Li, April 24, 2020, *The Toronto Star*; McKinley, April 20, 2020, *The Toronto Star*; National Post, April 1(i), 2020; The Toronto Star, April 20, 2020; The Toronto Star, April 28, 2020; Welsh, April 30, 2020, *The Toronto Star*). Discipline was most definitely used as a threat against nurses for non-compliance, in spite of the fact that nurses were using the one tool open to them to refuse work: unsafe work. Importantly, the CNO does not use failure to care as a means to discipline; disciplinary decisions are based on the standards and guidelines published by the CNO. Again, while caring is referred to in some of these documents (CNO, 2018; CNO, 2019c), it is not listed in any of the regulatory tenets. There is a disconnect here, as if caring was the essence of nursing, it seems probable that it would be listed in some of the regulations around nursing.

If any of the nurses had in fact been charged, they would have been brought to the disciplinary committee at the CNO. The CNO publishes the results of the summary judgements every four months. If the nurse decides to plead guilty to the charges, the member is called forward and asked to provide an account of their crimes. Confessionals are where the discourse most obviously displays its operation of power (Mills, 1997). Confession is very often associated with submission to power, with of course the most obvious example being pleading guilty to something. This is a demonstration of compliance with those who hold power. The threats of reporting nurses who questioned the safety of working without N95s relates directly back to Foucault's idea that the subjects of the discourse must be threatened with discipline in some way in order to ensure compliance with the discourse.

One aspect of discipline is surveillance, as it allows those in positions of authority to monitor the subjects of the discourse (Wheatley, 2005). The CNO practices surveillance on its members by having them complete a reflection journal and learning plan annually (CNO, August 20, 2020). The CNO can call on any nurse at any time to show them copies of these annual journals and learning plans. The CNO therefore regulates the nursing profession in Ontario by developing the standards for nursing in Ontario, upholding these standards, judging the fitness to practice of nurses who have been accused of wrongdoing, and delivering sentences. Surveillance is an essential component of power, as it allows those in a position of power to gather knowledge about the subjects of the discourse. Power is supported by knowledge of the subjects.

4.6 Circulation of the Discourse & Internal Regulation of the Discourse

Aside from the literature discussed in the literature review and the section on the history of the present, circulation of the caring discourse can be found in nursing schools (Dahlke & Wall, 2017) and some of the documents put out by nursing professional bodies that are intended to guide nursing practice (see RNAO, 2015; RNAO, 2002; CNO, 2019c). While none of these documents actually define what caring is, they do cite its importance. This will be discussed in more detail below.

Internal regulations to the caring discourse are best exemplified by the fact that it is professional nursing bodies that continue to propagate the caring discourse. As a brief reminder, internal regulation of the discourse refers to who is designated to speak with authority about the discourse (Mills, 1997). Both the RNAO and the CNO refer to the importance of caring in their professional literature and regulations. For example, in the document *Therapeutic Nurse-Client Relationship* (CNO, 2019c, p. 3), the CNO states that “applying caring attitudes and behaviors” are essential to establish and maintain the relationship between client and nurse. Power should

also be used in a “caring manner” (CNO, 2019c, p. 4). There are no references to how caring is defined by the CNO, or even to where the nurse might learn how to use power in a caring manner, or how to care, period. The RNAO document entitled *Establishing Therapeutic Relationships* (RNAO, 2002), caring by nurses is cited as a reason for reduced burnout rates among nurses (RNAO, 2002, p. 32). Knowledge of caring theories are cited as an essential tool for establishing therapeutic relationships (RNAO, 2002, p. 2). Unlike the CNO, the RNAO gives readers a chance to follow up on this information, as they provide the names of caring theorists such as Benner, Leininger, and Watson (RNAO, 2002, p. 3). In the RNAO document *Person and Family Centered Care* (2015), caring is used similarly throughout, with little to no reference to what caring may mean. A nurse is meant to convey “caring in order to deepen your understanding of the person’s needs” (RNAO, 2015, p. 26). Nurses need to use caring to elicit and respond to emotion (RNAO, 2015, p. 37). Nurses must provide caring environments (RNAO, 2015, p. 48). Verbal and physical behaviors must demonstrate caring (RNAO, 2015, p. 74, 77). Finally, caring is linked with providing holistic care (RNAO, 2015, p. 78). Circulation of the caring discourse is also provided through nursing academic literature, with many theorists focused on caring as an imperative for the nursing profession. Nursing education also stresses its importance (Dahlke & Wall, 2017).

As identified in the archive, nurses did not control the narrative around their own ability to control their safety. They were silenced internally by their administrators, scared to speak out as a result of a perceived punitive work environment. It was hospitals and the government who controlled the narrative by virtue of citing science. Nurses who vocally dissented against this idea of self-sacrifice were threatened with the loss of their job and/or being reported to the disciplinary committee.

Table 2.**Summary of Results of Analysis**

	The Toronto Star	National Post	The Globe and Mail
Physicians criticizing government or institutional response (Named)	Cribb, May 4, 2020, The Toronto Star	Riches, April 11, 2020	Grant & Mahoney, May 1, 2020, The Globe and Mail
	The Toronto Star, May 16, 2020		Weeks, March 11, 2020, The Globe and Mail
	Yang & Allen, March 21, 2020, The Toronto Star		
Nurses criticizing government or institutional response (Named)	Holmyard, May 15, 2020, The Toronto Star		
	Parks, Bain, & Jewell, May 18, 2020, The Toronto Star		
Physicians criticizing government or institutional response (Unnamed or pseudonym given)	DiManno, March 27, 2020, The Toronto Star	National Post, April 1(ii), 2020	
	DiManno, April 8, 2020, The Toronto Star		
Nurses criticizing government or institutional response (Unnamed or pseudonym given)	Arthur, April 2, 2020, The Toronto Star		
	Cribb, May 4, 2020, The Toronto Star		
	DiManno, April 1, 2020, The Toronto Star		
	Ferguson, April 2, 2020, The Toronto Star		
	Li, April 24, 2020, The Toronto Star		
	Warren, April 11, 2020, The Toronto Star		
Nurses depicted performing technical work, research, or medical procedures	Ogilvie, April 14, 2020, The Toronto Star		
Physicians depicted performing technical work, research or medical procedures	DiManno, April 8, 2020, The Toronto Star	National Post, April 4, 2020	
	Yang & Ogilvie, April 7, 2020, The Toronto Star		
Unnamed Nurses	Arthur, March 30, 2020, The Toronto Star	National Post, May 26, 2020	Grant & Mahoney, May 1, 2020, The Globe and Mail
	Arthur, April 2, 2020, The Toronto Star	National Post, April 28, 2020	
	Arthur, May 18, 2020, The Toronto Star		
	DiManno, April 1, 2020, The Toronto Star		

	DiManno, April 2, 2020, The Toronto Star		
	DiManno, May 9, 2020, The Toronto Star		
	McKinley, April 20, 2020, The Toronto Star		
	The Toronto Star, April 20, 2020		
	Welsh, April 5, 2020, The Toronto Star		
Unnamed Physicians	Arthur, April 2, 2020, The Toronto Star	National Post, May 26, 2020	
Reports of nurses expressing fear of retribution or punitive work environment, or sense of mistrust between floor staff and administrative task	Arthur, March 30, 2020, The Toronto Star	National Post, April 1(i), 2020	
	Arthur, May 18, 2020, The Toronto Star		
	Cribb, May 4, 2020, The Toronto Star		
	DiManno, April 1, 2020, The Toronto Star		
	Donovan, April 7, 2020, The Toronto Star		
	Li, April 24, 2020, The Toronto Star		
	McKinley, April 20, 2020, The Toronto Star		
	The Toronto Star, April 20, 2020		
	The Toronto Star, April 28, 2020		
	Welsh, April 30, 2020, The Toronto Star		
Physicians expressing fear of retribution or punitive work environment	(Purposefully left blank)		
Nurses depicted in feel-good stories (i.e. making emotional connections with patients or families, performing emotional work)	Arthur, May 18, 2020, The Toronto Star	National Post, March 17, 2020	Grant & Mahoney, May 1, 2020, The Globe and Mail
	Contenta, April 18, 2020, The Toronto Star	National Post, April 4, 2020	
	DiManno, April 2, 2020, The Toronto Star	National Post, May 26, 2020	
	Li, April 24, 2020, The Toronto Star		
	Ogilvie, April 14, 2020, The Toronto Star		
	Orms, March 22, 2020, The Toronto Star		
	Welsh, April 5, 2020, The Toronto Star		
	Welsh, April 30, 2020, The		

	Toronto Star		
Physicians depicted in feel-good stories (i.e. making emotional connections with patients or families, performing emotional work)	DiManno, April 14, 2020, The Toronto Star	National Post, May 1, 2020,	
	Ogilvie, April 14, 2020, The Toronto Star		
Reports by nurses of being actively denied N95s or told not to wear PPE	Arthur, March 30, 2020, The Toronto Star	National Post, April 1 (i), 2020,	
	Cribb, May 4, 2020, The Toronto Star	National Post, April 1(ii), 2020	
	DiManno, March 27, 2020, The Toronto Star	National Post, May 16, 2020	
	Li, April 24, 2020, The Toronto Star		
	McLean & Welsh, April 18, 2020, The Toronto Star		
	Parks, Bain, & Jewell, May 18, The Toronto Star, 2020		
	The Toronto Star, April 20, 2020		
Reports by physicians of being denied N95s	(Purposefully left blank)		
Speculation that N95s were being withheld as a result of supply issues rather than a safety issue	Arthur, March 30, 2020, The Toronto Star		
	Cribb, May 4, 2020, The Toronto Star		
	The Toronto Star, April 20, 2020		
	The Toronto Star, May 16, 2020		
Infectious disease experts or physicians stating or reported to have said there is no need for N95s	Cribb, May 4, 2020, The Toronto Star		Weeks, March 11, 2020, The Globe and Mail
	The Toronto Star, 2020 April 20		Weeks, April 3, 2020, The Globe and Mail
	Ward, March 15, 2020, The Toronto Star		
Shortage would leave a deficit for aerosolized procedures	Ward, March 15, 2020, The Toronto Star		Weeks, March 11, 2020, The Globe and Mail
			Weeks, April 3, 2020, The Globe and Mail
Nurses have more contact with patients than physicians	Arthur, March 30, 2020, The Toronto Star;		
	DiManno, March 27, 2020, The Toronto Star		
	DiManno, April 8, 2020, The Toronto Star;		
Physicians see fewer patients than nurses and/or been given direction on remote monitoring	The Toronto Star, April 20, 2020		
	Yang & Ogilvie, April 4, 2020, The Toronto Star		

Physicians expressing concern about their families	DiManno, March 27, 2020, The Toronto Star		
	Yang & Ogilvie, April 7, 2020, The Toronto Star		
Nurses expressing concern about the safety of their work environment, not PPE specific	Donovan, April 7, 2020, The Toronto Star		
Nurses expressing concern about their families	Arthur, March 30, 2020, The Toronto Star	National Post, April 4, 2020	
	Arthur, May 18, 2020, The Toronto Star		
	Ferguson, April 2, 2020, The Toronto Star		
	Parks, Bain, & Jewell, May 18, 2020, The Toronto Star		
	The Toronto Star, April 20, 2020		
	Ward, March 15, 2020, The Toronto Star		
	Welsh, April 9, 2020, The Toronto Star		
Nurses who believe it is their duty to care or who felt worthless, helpless due to inability to work	Keung, April 1, 2020, The Toronto Star		Grant & Mahoney, March 30, 2020, The Globe and Mail
	Monsebraaten, April 6, 2020, The Toronto Star		
Comparison to SARS	Cribb, May 4, 2020, The Toronto Star		
	Donovan, April 29, 2020, The Toronto Star		
	DiManno, April 8, 2020, The Toronto Star		
	Ogilvie, April 14, 2020, The Toronto Star		
	Parks, Bain, & Jewell, May 18, 2020, The Toronto Star		
	The Toronto Star, May 16, 2020		
	Yang & Allen, March 21, 2020, The Toronto Star		
	Yang & Ogilvie, April 7, 2020, The Toronto Star		
Articles where mental health issues for health care workers related to COVID-19 are discussed	Arthur, May 18, 2020, The Toronto Star	National Post, April 10, 2020	Igham, March 31, 2020
	DiManno, May 9, 2020, The Toronto Star	Riches, April 11, 2020	
	McKinley, April 20, 2020, The Toronto Star		

Government officials denying that there is a problem with supply issues	Arthur, March 30, 2020, The Toronto Star	National Post, April 1(ii), 2020	
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Chapter 5: Discussion

In this chapter, I discuss the origins of the notion of sacrifice within the caring discourse, directives on the refusal of work for both physicians and nurses from their regulatory bodies, the risks of associating caring with nursing, and draw a comparison between the situation of COVID-19 and the 2003 outbreak of the Severe Acute Respiratory Syndrome (SARS) in Ontario.

5.1 The Origins of Sacrifice in the Caring Discourse

Sacrifice and altruism were core concepts of the profession from its very early days (Dahlke & Wall, 2017; Reverby, 1987; Tierney, Bivins, & Seers, 2019). This idea of specifically feminine, sacrificial love is linked with ideas around motherhood (Dahlke and Wall, 2017; Van Nistelrooij & Leget, 2017). Caring (as a specific attribute) was not discussed in the early days of nursing, as it was simply assumed that, as women, nurses would be caring (Dahlke and Wall, 2017; Dunlop, 1986). What was stressed were the feminine virtues of the nurse (such as tenderness, nurturing, morality, self-sacrifice, and devotion to duty), attributes that were borrowed from nuns who provided care for the sick and identified by nursing reformers and government bureaucrats across North America and Europe as essential characteristics of a nurse (Gordon & Nelson, 2006).

In order to discuss the contemporary social benefits of the discourse, we must revisit the past. In the first half of the 19th century, the majority of people who were ill were cared for at home; hospitals were rarely used by anyone except the very poor (Hawkins, 2010a). This may have been because hospitals were not as well-regarded back then as they are today. (Sellman, 1997). In the latter half of the 19th century, hospitals underwent a period of transformation and sought to increase the number of clientele that they served (Hawkins, 2010a). It can therefore be

said that nursing in the nineteenth century was the first venture of the state into public health, with care being extended from the private sphere into the public sphere (Dunlop, 1986).

The advent of the modern hospital required a workforce that would act as a substitute for the care that a patient would receive at home (Gordon & Nelson, 2006). Prior to Nightingale, nuns were often associated with nursing and caring for the sick. (Gordon & Nelson, 2006). However, outside of religious orders, nursing was a profession that was often associated with sloth, alcoholics, and women who were in the lower classes of society (Hawkins, 2010b; Hawkins, 2010c; Sellman, 1987). Nurses could be either trained or untrained, and basically anyone was able to call themselves a nurse (Reverby, 1987). Up to the early 1900s, training, not education, was the key to becoming a nurse (Reverby, 1987), although classroom training did occur (Ruby, 1999). Hospitals, too, suffered from a poor image, with many of them perceived to be dirty, overrun institutions (Hawkins, 2010a; Sellman, 1997).

In order to make nursing a “respectable” profession that could be taken up without scandal by the Victorian middle-class women, it was essential to frame nurses in such a way that their perceived moral character and virtue remained intact, as middle-class women who worked outside the home risked being perceived as impure (Digby, 1992). A respectable middle-class woman living in Victorian England could not be associated with the nursing profession unless there were some very definite changes made to the way it was perceived. Framing the profession as one that embraced self-sacrifice, altruism, and charity allowed women to take up work outside the home without being negatively socially stigmatized (Gordon & Nelson, 2006). In conceptualizing the nursing profession in this specific manner, a place was made in this new healthcare system for legions of women to take up work outside of the home while retaining their respectability (Gordon & Nelson, 2006; Hawkins, 2010a). In their new roles as nurses, women

were expected to continue to fulfil the roles that they filled in the private sphere. Social norms dictated their behavior both at home and at the workplace.

By placing the emphasis of nursing on caring, an attribute situated in the private sphere, the nursing profession was able to be placed firmly within the socially permissible private sphere, essentially allowing for an extension of the private sphere into the public one (Hawkins, 2010a). The extension of the private sphere to work outside of the home provided space to middle-class and upper-class woman to work outside of the home without contradicting the social mores of the day. In this way, middle-class women could enter the nursing profession as a means to pursue their philanthropic and caring projects, using the hospital as a place to provide teaching around the moral and spiritual well-being of their new patients, all while maintaining their societal respectability (Hawkins, 2010a).

Care in the private sphere in Victorian England was often associated with love, but in the public sphere, there was an attempt to remove love from this equation in order to make caring make sense (Dunlop, 1986). Love was inextricable with the idea of care, and there would have been very few in middle-class Victorian England who would have argued against this conceptualization of nursing (Dunlop, 1986). One of the elements of home care was the presence of a female caregiver, typically a family member (Hawkins, 2010a). Recreating the private sphere within the public one by replicating the role of “female as caregiver” via the nurse may have served to make public health a more hospitable place for the middle and upper class who preferred to be cared for at home (Hawkins, 2010a). It could therefore be said that the hospital nurse was used as a means to simulate the home environment in the clinical environment, with nurses playing the role of mother to the patients (Hawkins, 2010a). This had the added effect of reinforcing the patriarchal hierarchy, as physicians were in charge of the nurses (Hawkins,

2010a). The difficulty with this concept is that it does not remove caring from the domain of the feminine (Dunlop, 1986). To this day, there remains in place an idea that the nurse is there to stand in for the family, channeling the family's love in such a way that the patient feels as if they are with family (Dunlop, 1986).

As Reverby (1987) has shown, nurses assumed the role of caring as a shift was made from caring for the ill at home to the hospital. In order to be viewed as a caring and "good" nurse, Reverby (1987) states that, "altruism, sacrifice, and submission were expected, encouraged, indeed, demanded" (p. 7). Motherhood was also associated with the idea of self-sacrifice (Dahlke & Wall, 2017; Reverby, 1987; Van Nistelrooij & Leget, 2017). The profession of nursing was founded during a time when it was believed that men and women had specific biological traits that made them naturally more competent in certain areas (Mosedale, 1978). There was an additional emphasis on the role of the hospital as a home for the sick, with nurses taking on the role of the mother (Hawkins, 2010a). Nightingale herself had likened the relationship between nurse and client as that of mother and child (Hawkins, 2010a). Saginak and Saginak (2005) argue that many of the ideas we have about gender today are rooted in these Victorian ideals of gendered biological differences.

As a product of their times, health care institutions and physicians would have insisted that the nurses were of good character (Hawkins, 2010a). The institutions in charge of shaping nurses' behavior were the newfound nursing schools. These schools were often run by the hospitals themselves (Reverby, 1987). Nurses learned how to behave in school, and this behavior needed to be in line with the strict moral code of the day (Reverby, 1987). The institutions that nurses worked at maintained the absolute right to discipline nurse's behavior, as all of these attributes were expected from a nurse (Reverby, 1987). It was not just moral behavior that was

expected, but the associated attributes of caring were also ingrained in the profession at this time. In this way, educational institutions became complicit with continuing the caring discourse in the nursing discipline. As Dahlke and Wall (2017) have noted, caring is still consistently presented as a normative value in nursing education and texts, in spite of the fact that it remains an ill-defined concept (Paley, 2001).

As concepts in nursing in the Victorian era, caring and morality were intertwined. By capitalizing on the script that women were morally superior and possessed the capacity to provide care in a way that men were biologically unable to, the modern-day version of the nursing profession was born (Gordon & Nelson, 2006). As a result, a nurse's character was most important in these early days of professional nursing (Sellman, 1997). In fact, morality remains so entwined with the professionalism of nursing to this day that any act of perceived immorality from a nurse is now equated with professional misconduct (Sellman, 1997). The CNO itself discusses the "moral fitness" of the members before them in the many of the cases that it hears at the disciplinary tribunal (for example, see CNO Sept. 15, 2008; CNO February 23, 2011; CNO September 26, 2018). It is important to point out that most of the cases that make it to the CNO tribunal are often quite severe in nature and most people would say the accused acted in a morally questionable manner. However, the wording used by the CNO in their summary judgement reinforces their dominion over the moral character of the nurse, along with emphasizing the importance of morality within the profession itself. Moral education remains part of the unwritten curriculum of today's nursing schools and these standards are meant to be followed whether the nurse is on or off duty (Sellman, 1997). Both caring and morality were expected attributes of the nurse; an uncaring nurse cannot be moral, and an immoral nurse cannot be caring.

The result of all of this was that caring was subsumed into the nursing profession without encountering many difficulties nor was the insertion of caring into the profession met with much resistance. As nursing entered the 20th century, characteristics such as self-abnegation, sacrifice, service ethics, and moral character were lauded by nursing leaders of the day (Reverby, 1987). This sense of altruism, virtue, and morality expected from nurses has been subsumed into the leading caring theories of the day. For example, Watson's Caring Science Institute (2020) explicitly lists altruism as one of her processes of caring. Patient-centered care, which on the one hand is a highly laudable goal, necessarily places the nurse as secondary in any relationship that they develop with a patient. Certainly, the goals of patient-centered care are not necessarily dictating actual self-sacrifice, but there remains a quiet but occasionally audible undertone of self-sacrifice embedded in the application of this ideal. Nurses who are so regularly busy at work that they are unable to take breaks, for example. The ideals of caring and self-sacrifice remain an expectation of the profession to this day (Valiani, 2003), perhaps at least in part due to the insertion of the caring discourse into the nursing profession.

The initial arguments for the presence of "care" while in hospital may arise from the public's desire to be cared for when ill, memories that many of us have from childhood, and is a task often associated with the mother figure. While caring theorists may not intend for their use of the word caring to evoke images of motherhood and sacrificial love, there remains an historical association of the word with these concepts, making it difficult for both nurses and patients to differentiate the two (Dunlop, 1986). In addition, this historical conceptualization of caring means that any resulting difficulties with caring, regardless of whether they are structural or a result of the evolution of the nursing practice, can be viewed as the result of inherent deficiencies of the nurse as a human being (Dunlop, 1986). This places an unfair burden

on nurses, as their personal identities are now inextricably intertwined with their professional ones.

This association of caring with sacrifice has been found in student nurses. Dobrowolska and Palese (2016) state that prior to clinical placements, student nurses were more likely to equate caring with self-sacrifice and selflessness. These associations harken back to the exact same associations made around caring during the Victorian Era. This finding further suggests that these associations are present prior to even beginning nursing school. It therefore seems likely that the association of caring with self-sacrifice is the result of a perceived social norm or social conditioning. Students described caring as selfless and sacrificial, devotion, equated with goodness, an expression of love and interest (Dobrowolska & Palese, 2016). This is congruent with the conceptualization of caring present at the turn of the 19th century that was embedded into the nursing discourse.

However, students' perceptions around how nurses care changed after their first clinical placement (Dobrowolska & Palese, 2016). While their original conceptualization of caring remained, students added additional concepts of caring to their own personal definition of the term. Their ideation of caring was expanded upon once they entered the clinical environment, but they did not dispose of their original concepts of caring. The implications of this are that caring takes on a special meaning within nursing, but that the core concept of the idea, formed via societal norms, does not change. In addition, this implies that non-nurses, who lack experience with the clinical environment, may have different expectations of what caring looks like than nurses. Non-nurses may have formed an ideation of caring that lacks the same conceptualization of care that nurses have based solely on societal norms. The result is that nurses and the public may have very different concepts of what good nursing actually is. Non-nurses may have

conceptualizations of caring in line with societal norms, whereas nurses conceive of it in a specialized way. This may result in a disconnect between what is expected by the patient and what is provided by the nurse. This also demonstrates how socially conceived norms permeate our interpretation of the world around us.

As discussed in the analysis of the archive, the discourse of caring permeates what nurses are and are not allowed to speak out about. Nurses have reported being disciplined by their employers when they speak out about medical matters, but not if they speak about caring, advocacy, or their humanistic role (Gordon & Nelson, 2006). These unspoken rules about what nurses can and cannot speak publicly about. These restrictions impact how the public views us and shapes the perception of the nursing profession. The discourse of caring is reflected back to everyone, both nurses and non-nurses, and may be internalized by both. These assertions made by nurses were demonstrated in the archive. In the archive, physicians were typically portrayed as researchers and the perpetrators of medical interventions, whereas nurses were turned to for feel good stories. Nurses who did attempt to criticize either the response of the government or their institution were often too scared to attach their name to anything printed. The restrictions placed on nurses who attempt to speak around anything other than humanistic skills or attitudes effectively helps silence nurses, provides others with the space to speak for them, and plays a role in the organization of the public perception of the profession.

In the end, all of these factors contribute to the reproduction of the gendered divisions produced in the 19th century between nurses and physicians, in spite of the fact that the profession has changed immensely since then (Gordon & Nelson, 2006). Nursing is still positioned as a profession to enter if you want people to love you, be perceived only as a helper (regardless of your education level), caring, altruistic, “always there”, noble, and virtuous

(Gordon & Nelson, 2006). Media representations of nurses typically reproduce this idea of what nursing is, resulting in a perpetuation of this ideal (Gordon & Nelson, 2006). This conceptualization of caring may change once nurses enter the clinical environment (Dobrowolska & Palese, 2016), resulting in an disconnect between what the patient expects and what the nurse is able to provide. There remains a tension between what is put forward as normative of nursing and what nursing actually is.

5.2 Directives on the Refusal of Work

The right of access to PPE was a theme that was prevalent throughout much of archive. Nurses' requests for N95s and the refusal of access to them can be connected to the discourse of caring. In order to understand how issues of safety and PPE are related to the caring discourse, it is important to look at a nurse's ability to refuse work. Like the medical profession, nursing is a self-regulated profession. The College of Nurses of Ontario (CNO) is the main regulatory body of nurses within Ontario. The CNO is the authority for setting the standards for entry-to-practice, enforcing standards of practice and conduct, and articulating and promoting standards of practice (CNO, May 25, 2017). The document *The Nursing Act, 1991* lays out the professional responsibilities of nurses in Ontario (CNO, 2017). While the word "abandonment" is not used in the regulatory literature related to refusing assignments (CNO, 2017), it is implied that doing so may legally result in a case of professional misconduct. Even if they are not held criminally responsible patient abandonment, nurses may be reported to the CNO for misconduct, resulting in fines or suspension/loss of their license. The CNO suggests in place of work refusal that nurses advocate for a quality work environment (CNO, 2017).

In addition to rules laid out in the CNO document *Refusing Assignments and Discontinuing Nursing Services* (CNO, 2017), The Ontario Ministry of Health implemented an

emergency act on March 21, 2020 that gave hospitals sweeping powers over their staff, overriding many of the existing union agreements and superseding *The Nursing Act, 1991*. The emergency act put forward by the Ontario government gave health care facilities the ability to refuse and cancel nurses vacation plans, redeploy them where they felt was necessary, train them for redeployment, and even suspend any grievances that might arise from the execution of this order (Watts, Wells, Newell, & Putyra, March 26, 2020). The emergency act overrode almost all of the rights that a nurse had for the refusal of work. This left nurses with little recourse for work refusal unless they did so under the auspices of the Occupational Health and Safety Act, which workers can do if they decide that the work is inherently unsafe (Watts et al., March 26, 2020). The CNO did not step in and provide any contingencies for the refusal of work for nurses during COVID-19. The nursing regulatory body in Ontario instead relied on its suggestion that nurses advocate for a quality work environment instead of outrightly refusing work (CNO, February 2020). The analysis of the archive indicated that nurses were critical of the government or institutional response and often did not feel safe (Arthur, April 2, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*; DiManno, April 1, 2020, *The Toronto Star*; Ferguson, April 2, 2020, *The Toronto Star*; Li, April 24, 2020, *The Toronto Star*; Warren, April 11, 2020, *The Toronto Star*). However, as some nurses indicated, the fear of retribution within the workplace likely did not allow much space for productive conversation (Arthur, March 30, 2020, *The Toronto Star*; Arthur, May 18, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*, DiManno, April 1, 2020, *The Toronto Star*; Donovan, April 7, 2020, *The Toronto Star*; Li, April 24, 2020, *The Toronto Star*; McKinley, April 20, 2020, *The Toronto Star*; National Post, April 1(i), 2020; *The Toronto Star*, April 20, 2020; *The Toronto Star*, April 28, 2020; Welsh, April 30, 2020, *The Toronto Star*). At times, there was an overt attempt to silence nurses who attempted to

advocate for their own safety by health care facilities (DiManno, 2020 April 1, *The Toronto Star*), which limits a nurse's ability to advocate for a quality practice environment, as the CNO suggests nurses do when questions of safety and work refusal arise, placing nurses in a Catch-22 type of situation.

The College of Physicians and Surgeons of Ontario (CPSO) gives physicians explicit advice on how to conduct themselves during a public health emergency and also has a page dedicated to questions specific to COVID-19 (College of Physicians and Surgeons of Ontario [CPSO], 2018; CPSO 2020). As mentioned earlier, the CPSO directs physicians to provide as much virtual care as possible (CPSO, 2020). They are directed to make virtual care their primary mode of care, provided it is appropriate. Safety precautions are detailed extensively, for both physician and patient. CPSO even details what items are necessary for safety and makes recommendations for the placement of items such as hand sanitizer. In public health emergencies, physicians, unlike nurses, are told that they are able to refuse to provide direct medical care if it may affect their own health, their family members, or others who are close to them (CPSO, 2018). Provided that the physician is able to provide a legitimate reason for refusal of care, physicians can be exempted from providing direct physical care during a public health emergency.

A physician's ability to refuse work based on concerns about their own health, coupled with the fact that physicians typically have less patient contact than nurses indicates that the regulatory bodies place more value on keeping physicians safe than nurses. As mentioned in some of the articles included in the archive, there is recognition in the articles included in the archive that nurses see more patients and also have to take their PPE on and off more times than a physician. The result of this is that nurses most likely have an increased chance for the

transmission of disease, decreasing their own ability to protect themselves. What appears to be at work here is an assumed, unstated position that, if necessary, nurses should be prepared to sacrifice themselves for the greater good. It also speaks to the perceived value of physicians and nurses. Physicians are given the tools to protect themselves, both from their regulatory body and in terms of PPE. Nurses, often portrayed as faceless and nameless throughout the archive, had to fight for access to the PPE they felt was necessary, and have no equivalent means to refuse work. The discourse of caring, that positions nurses as self-sacrificial, impacts the way that nurses are perceived and treated.

One other aspect of placing physicians' safety above that of nurses surrounds the questions of restricting access to N95s. One possible interpretation for restricting use of the N95s can be found in considering who they were saving the N95s for. It is physicians who intubate or scope, although they are typically aided by nurses. It is possible to infer that the underlying, unstated reasoning behind limiting PPE was that physicians might need them in the future for aerosolized procedures. It is important to note that I am not arguing that this is an invalid point or even that this necessarily was everyone's conscious reasoning. The commonly understood reason for the rationing of masks was to make the existing supply last longer, which does make logical sense. However, I am presenting an alternate analysis that might serve to answer the question: who are we saving the masks for, exactly, when healthcare workers are asking to be protected now and the science is new and uncertain? There is a cost to conserving PPE, and that cost is healthcare workers. In this case, the specific cost was nurses, due to their increased contact with patients, and also due to the directives for physicians to conduct as much care as possible virtually. In effect, it was possible for a physician to remain physically distant from patients, whereas nurses had no such options. Nurses placed in a situation where they were expected to

sacrifice themselves in order to preserve PPE for physicians and also to account for any potential issues with supply.

The argument here does not depend on whether or not physicians used the stipulation provided by their College to refuse work should it put their health unduly at risk; I do not have access to any records surrounding the number of physicians who declined to treat patients during COVID-19, citing risks to their health. It is likely not very many. However, the lack of a similar stipulation in the College of Nurses of Ontario points to an underlying discrepancy in how the two groups are treated and perceived. The inability to effectively refuse work puts nurses in a much more dangerous position than physicians. Ultimately, this demonstrates the value that society places on each profession. It also relates back to the discourse of caring and the concept of sacrifice that is embedded within that discourse.

This situation placed nurses in the position of being forced to continue to provide care in-person without being provided with any real space to refuse unsafe work. The expectation that nurses work without regard to their own or their family's health was effectively legislated. Nurses were essentially backed into a corner, with little support from the CNO and with experts stating that the science indicated that surgical masks were sufficient, in spite of the fact that the science was evolving daily. As demonstrated in the archive, nurses that did attempt to advocate for a quality work environment were threatened by their employers, and the majority of nurses who were quoted in the archive requested that their names not be used due to fear of retribution. The issue got so contentious that the Ontario Nursing Association took the issue to the Supreme Court, who ruled that healthcare workers need to be provided with whatever PPE they deem necessary. This ruling was based at least in part on the role of the precautionary principle, which

was recommended as the standard for healthcare workers after the 2003 outbreak of the Severe Acute Respiratory Syndrome (SARS) in Ontario.

5.3 SARS

At this point, it is worth going over the story of PPE during the SARS outbreak in Ontario, 2003. The resemblances between it and the situation that emerged during COVID-19 are significant. SARS only reached 375 cases in Ontario, but thousands were asked to quarantine at home due to potential infection (Ontario Ministry of Health and Long-Term Care, 2018). Out of the 375 cases, 169 of those infected were health care workers (Campbell, 2006c). The crisis lasted approximately 6 months, with the majority of cases found in Toronto (Ontario Ministry of Health and Long-Term Care, 2018). A total of 44 deaths were recorded overall (Ontario Ministry of Health and Long-Term Care, 2018). Two nurses and one physician died during the outbreak (Campbell, 2006c). A state of public emergency was declared, but once the outbreak was declared officially over, a Commission was put in place to analyze the failures that occurred at healthcare facilities around the management of the disease at that time. The Commission was headed by The Honorable Archie Campbell and it is from this report that much of my discussion around SARS will be drawn.

The province's history with SARS and the findings of the SARS Commission made it clear that when the science is unclear, it is better to err on the side of caution and provide a higher level of PPE than is initially thought (Campbell, 2006c; Ontario Nurses' Association, April 26, 2018). This decision was reached as a result of what is typically considered to be the mishandling of the SARS outbreak in Ontario. Almost half of the total cases of SARS in Ontario were contracted by healthcare workers while they were working, due at least in part to the fact that infectious disease specialists misunderstood the exact nature of the transmission of the virus

(Campbell, 2006b). One of the results that emerged from the commission's report was to develop something now known as the precautionary principle (Campbell, 2006c). The precautionary principle states that when the science is uncertain, the highest level possible of protection should be used (Campbell, 2006c). In spite of the SARS Commission's findings, healthcare institutions have continued to withhold masks during the COVID-19 outbreak, citing the scientific literature that has emerged during the outbreak. As it turns out, what happened during the COVID-19 in Ontario in the Spring of 2020 is very similar to what happened during the SARS outbreak in Ontario, 2003. The province of Ontario not only demonstrated how unprepared it was for another outbreak of a novel disease, but also demonstrated that it failed to heed all of the advice that arose from the commission that was formed in the aftermath of the SARS outbreak.

As mentioned above, during the SARS outbreak there were initial questions over the nature of transmission of the virus. Early on, infectious disease specialists insisted that SARS was spread through droplets and was not airborne, indicating the use of a surgical mask, and not N95s (Campbell, 2006b). Health care workers were directed to use surgical masks only, and access to N95s was restricted (Campbell, 2006b). As Justice Campbell pointed out, the decision to provide N95s is not about science, but safety (2006b). Not only can scientific knowledge change, but accidents can also occur, causing unexpected exposure. However, based on the science, the risk of airborne transmission was dismissed, contributing to the death and illness of many healthcare workers.

There were similar occurrences during the COVID-19 outbreak in the Spring of 2020. As discussed in the archive for this paper, many infectious disease specialists advocated for the use of surgical masks instead of N95s during COVID-19 (Cribb, May 4, 2020, *The Toronto Star*; The Toronto Star, April 20, 2020; Ward, March 15, 2020, *The Toronto Star*; Weeks, March 11,

2020, *The Globe and Mail*; Weeks, April 3, 2020, *The Globe and Mail*). As of now (July 2020), evidence is emerging that airborne transmission of COVID-19 might be more prevalent than previously thought (World Health Organization, 2020). Even if COVID-19 is not as contagious as some other airborne viruses such as the measles or tuberculosis, at the very least it appears that the exact nature of transmission of the virus is still under investigation.

During the SARS outbreak, there were similar disagreements over access to PPE. The prevailing attitude at that time was that nurses were supposed to do as they were told regarding PPE, in spite of the fact that information was changing daily (Campbell, 2006a). Those who questioned the efficacy of the PPE provided were “belittled and shouted at” at certain sites (Campbell, 2006a, p. 993). Hospitals were refusing to provide N95s to nurses, in spite of the fact that the disease was spreading through the healthcare staff (Campbell, 2006b). Nurses were asked to re-use masks from day-to-day (Campbell, 2006a). Cost was considered when doling out masks, and, in fact, management sent out emails detailing exactly how much SARS had cost the hospital (Campbell, 2006a). The budget was given greater priority than nurse welfare (Campbell, 2006a). Nurses were told to deal with the conditions as they were, and that if they did not like it, they should not be in the profession (Campbell, 2006a).

As with the situation with SARS, nurses who worked through the spring of 2020 with COVID-19 that disagreed with the advice around masks or who voiced their concerns were sometimes silenced via overt threats or through the fear of retribution within the workplace (Arthur, March 30, 2020, *The Toronto Star*; Arthur, May 18, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*, DiManno, April 1, 2020, *The Toronto Star*; Donovan, April 7, 2020, *The Toronto Star*; Li, April 24, 2020, *The Toronto Star*; McKinley, April 20, 2020, *The*

Toronto Star; National Post, April 1(i), 2020; The Toronto Star, April 20, 2020; The Toronto Star, April 28, 2020; Welsh, April 30, 2020, *The Toronto Star*).

Nurses and physicians were held to different standards during SARS. Nurses were expected to follow the rules regarding PPE. Physicians, on the other hand, were often noted not following the rules regarding PPE, and needed to be reminded to do so by nurses (Campbell, 2006a). Some physicians outright refused to wear PPE or go through the SARS screening everyone else had to go through to enter the hospital, or follow other protocols (Campbell, 2006a). Some nurses noted that the managers listened to the opinions of the physicians instead of the RNs, who were working at the bedside (Campbell, 2006a). One nurse noted that their hospital did not take heed of the requests from nurses for more PPE, but when one physician expressed concern, the PPE was immediately provided (Campbell, 2006a). Nurses had to work hard to be heard (Campbell, 2006). Nurses expressed their concerns about lack of appropriate PPE to senior physicians and hospital administrators at that time but were nonetheless expected to come in when they were symptomatic and pressured to work overtime and double shifts (RNAO, 2003). Physicians and nurses did not have to follow the same rules, and nurses' opinions were not listened to, showcasing the double standard that is still evident today.

As shown in my discussion around the ability to refuse work during COVID-19, nurses and physicians continue to be held to different standards, highlighting the sense of value that society affords to their respective professions and regulatory bodies. Nurses are expected to be present at the bedside, at any cost, whereas physicians are provided with the options to work remotely or to refuse work that may put them or their family members in harm's way (CPSO, 2018; CPSO, 2020). In the archive, more physicians felt comfortable expressing negative positions around how the province and healthcare institutions were handling the COVID-19

outbreak, feeling more confident in attaching their names to quotes in the various newspapers (Cribb, May 4, 2020, *The Toronto Star*; Grant & Mahoney, May 1, 2020, *The Globe and Mail*; The Toronto Star, May 16, 2020; Riches, April 11, *National Post*; Weeks, March 11, 2020, *The Globe and Mail*; Yang & Allen, March 21, 2020, *The Toronto Star*). Physicians are afforded more leeway than nurses to express themselves freely (as they did in the archive) and to practice in the way that they best see fit (as evidenced by their regulatory body). Nurses were accorded no such luxuries, either during SARS or COVID-19.

Nurses felt that information had been kept from them about the seriousness of SARS (Campbell, 2006a). One nurse who worked during the SARS outbreak stated that nurses were not allowed to speak to one another in order to prevent the sharing of information (Hospital News, n.d.). While there have not been any reports yet regarding nurses not being allowed to speak to one another during the COVID-19 outbreak, there has been a definite pattern of silencing nurses. As shown in the results from the archive, some nurses chose not to have their name published when criticizing the response to COVID-19 (Arthur, April 2, 2020, *The Toronto Star*; Cribb, May 4, 2020, *The Toronto Star*; DiManno, April 1, 2020, *The Toronto Star*; Ferguson, April 2, 2020, *The Toronto Star*; Li, April 24, 2020, *The Toronto Star*; Warren, April 11, 2020, *The Toronto Star*). One nurse who asked publicly for donations of PPE on social media was rumored to be potentially under consideration to lose her job as a result of that post (DiManno, April 1, 2020, *The Toronto Star*).

In addition, there was a tendency to talk about nurses as if they were objects in the room, instead of people (Arthur, March 30, 2020, *The Toronto Star*; Arthur April 2, 2020, *The Toronto Star*; Arthur, May 18, 2020, *The Toronto Star*; DiManno, April 1, 2020, *The Toronto Star*; DiManno, April 2, 2020, *The Toronto Star*; DiManno, April 9, 2020, *The Toronto Star*; Grant &

Mahoney, May 1, 2020, *The Globe and Mail*; McKinley, April 20, 2020, *The Toronto Star*; National Post, May 26, 2020; *The Toronto Star*, April 20, 2020; Welsh, April 5, 2020, *The Toronto Star*). Nurses were often referred to as “a nurse” when detailing tasks that they performed, instead of giving them a name. While this certainly could be explained as a simple narrative technique, designed to keep the story simple, the result of this is that nurses appear to be interchangeable, and perhaps even disposable. It was as if they were comparable to inanimate objects in the room; there to perform a function, but with no underlying personality, fears, emotions. It lent a feeling of disposability to the nurses in the narratives; as if one could very easily be exchanged for another. Nurses that worked during SARS also stated multiple times that they felt disposable (Campbell, 2006a). These feelings of disposability and interchangeability are reflected in their textual representations.

By the end of the SARS outbreak in Ontario, nurses felt devalued, distrustful, as if they had not been looked after by either the province or their employers, more aware of the dangers of the profession, unprotected, underappreciated, unsupported by their superiors, expendable, as if the job could kill them or their family, or like a human defense against the spread of disease (Campbell, 2006a). Some, on the other hand, felt proud of being called a hero and happy to be perceived as dedicated (Campbell, 2006a). Post-SARS in Ontario, the number of nurses who considered resigning from nursing altogether rose (Mavromichalis, 2003). As demonstrated in the archive, the situation during COVID-19 was similar, with nurses feeling as if their worth was reduced to 2 masks and a brown paper bag and worried about the health of their families (Ferguson, April 2, 2020, *The Toronto Star*). It is too early to gather any evidence on whether or not COVID-19 has made nurses consider resigning. However, based on the experiences of SARS, it may occur.

As discussed in the archive, nurses during COVID-19 have had to fight yet again for access to PPE, taking their claims to the Superior Ontario Court so their employers would unlock access to N95s. N95 use was being restricted during SARS in a similar manner and for similar reasons as it has been during COVID-19. Nurses objected to being denied masks in both SARS and COVID-19, but each time were told that they were safe by experts (Campbell, 2006b; Cribb, May 4, 2020, *The Toronto Star*; The Toronto Star, April 20, 2020; Ward, March 15, 2020, *The Toronto Star*; Weeks, March 11, 2020, *The Globe and Mail*; Weeks, April 3, 2020, *The Globe and Mail*). Science was used as a means to silence nurses both times, in spite of the fact that the science was still evolving in both cases. In addition, the implication was that nurses should not only do as they are told, but that they should be willing to sacrifice themselves, as “this is what they signed up for” (Campbell, 2006b; Cribb, May 4, 2020, *The Toronto Star*)

The situations of SARS and COVID-19 are therefore quite similar. There is a theme of government-mandated self-sacrifice underlying many of the situations that took place during both outbreaks. Taken together, the story of SARS and COVID-19 in Ontario suggests a willingness on the behalf of the government to sacrifice nurses in the name of cost-saving. In fact, Valiani (2013, p. 1) writes that nurses were knowingly sacrificed through the Ontario Ministry of Health’s directives of use of PPE during the SARS outbreak in Ontario. Valiani writes that the sacrifice of nurses is an “under-recognized but regular practice in Ontario” (i.e., the sacrifice of nurses does not take place only during public health emergencies). Valiani calls it the cycle of sacrifice in nursing, and it revolves around understaffing and the resulting emotional exhaustion. Routine understaffing leads to overwork, resulting in exhaustion (Valiani, 2003). As a result of this understaffing, overwork, emotional exhaustion, stress, burnout & injury, sick leave, controls, and leaves of absence are common (Valiani, 2003). There is a dependence on

relying on nurses to commit to overtime just to be safely staffed instead of hiring the appropriate amount of staff initially. All of this is done knowingly and can therefore be understood as a cycle of sacrifice.

The result is that nurses in Ontario are continuously subjected to this cycle of sacrifice, and the healthcare system is dependent upon it, both during and outside of public health emergencies. The problems inherent in the healthcare system in Ontario are only exacerbated during public health emergencies, making them more visible. The positionality of the nursing profession remains one of these problems. Nurses are routinely expected to sacrifice, regardless of the circumstances.

The exact same can be said for the work of nurses during a public health emergency; nurses are expected to commit to at least some degree of self-sacrifice for the greater good. While it remains unstated, there remains an expectation of self-sacrifice: for overtime, for emotional labor, or in the case of COVID-19, safety or health. However, the potential for bodily harm as a result of this self-sacrifice becomes apparent during a public health emergency such as COVID-19, since it is a novel disease, and much was still being discovered about it. There were a number of unknowns during the early days, bringing the pressures inherent within the system to a head. The cycle of sacrifice can almost be accepted absent a pandemic, as nurses who take a leave of absence, sick leave, or simply quit the profession will not do so en masse. The effects of those leaving the workforce can therefore be mitigated outside of a public health emergency. The crisis that occurred at the outset of the COVID-19 pandemic in Ontario forced these issues to be pushed to the forefront. The regulatory body and provincial laws are designed in such a way so as to minimize the means that nurses have to excuse themselves from work, forcing them to sacrifice themselves on some level so that the healthcare system can continue to provide the care

that it has promised to the population. There was very little room for nurses to maneuver during the COVID-19 outbreak in the Spring of 2020, and when nurses did attempt to take control of the narrative, they were threatened with punishment and silenced with science.

As discussed, there were a number of similarities between the situation with SARS in Ontario and the current situation with COVID-19. The underlying attitude around protecting nursing staff during a viral outbreak appears to be too little, too late. The reasons that nurses seem to be positioned to repeat this pattern may come down to some of the underlying assumptions about the profession, as demonstrated in the archive: nurses are disposable, interchangeable, they want to help, are mandated to help, and should be readily self-sacrificial.

The discourse of caring therefore has real-world implications for nurses. Nurses have a duty to care that is similar to physicians. However, it is telling that the CNO does not include a clause that allows nurses to be excused from providing bedside care during a public health emergency when physicians do (CPSO, 2018). This may hint at an underlying belief in the differing views on the perceived importance of either profession, the power of each profession, and the duties of each profession.

Chapter 6: Conclusion

Moving past the historical conception of nursing as a sacrificial act is imperative if nurses wish to re-focus the conversation on their skills, knowledge, and humanity (Dahlke & Wall, 2017). Situating caring as the essence of nursing has the potential of reinforcing the historical expectation of self-sacrifice from nurses, in both an emotional and physical sense (Dahlke and Wall, 2017). By stressing caring, ethics, emotion, and virtue instead of knowledge and contributions, nurses are subject to continued assaults on the integrity of their profession and their role in research, as it is difficult to defend the position of nurses as critical members of the healthcare team when they are unable to articulate their role beyond the scope of caring (Nelson & Gordon, 2006a). Moving beyond caring will place more of an emphasis on skills that are recognizable to the public and administrators as valuable, while keeping some of the focus on the relational nature of nursing (Dahlke & Wall, 2017). Doing so will help to solidify their role in healthcare systems and allow for others to recognize their worth (Dahlke & Wall, 2017).

Unless nurses move past association their profession with caring, nurses will remain stuck in what is known as the virtue script, based on a gendered division of labour, while other professions have moved forward (Gordon & Nelson, 2006). The virtue script includes acts of caring, morality, and general, all-around “goodness” (McAllister & Brien, 2016). Focusing on the virtuous, caring aspects of nursing necessarily diminishes the focus on the skilled work that nurses do (McAllister & Brien, 2016). In addition, the virtue script cannot adequately explain the irreverence, deviance, or negligence that can occur within the nursing world (McAllister & Brien, 2016). In other words, the virtue script cannot explain what Foucault terms discontinuities and exclusions to the discourse. By allowing themselves to be the subject of feel-good stories about hand-holding and special moments, the true skills of the nurse remain hidden from view

(Nelson & Gordon, 2006b). The association of the nursing profession with goodness and caring does not address almost all aspects of the nursing profession as it stands today.

Some nurses in the archive stated that they felt helpless or worthless when placed in a position where they were unable to work. One nurse who was due to be deported due to a clerical error on her part stated that “it hurts” and that she felt “unworthy and helpless” knowing that she was not able to work at this time (Keung, April 1, 2020, *The Toronto Star*). Another nurse stated that she returned to work before getting the results from her COVID-19 test back out of a sense of “duty”, and that she owed it to the patients to “take care of them” (Grant & Mahoney, March 30, 2020, *The Globe and Mail*). A nurse practitioner working in a COVID-19 assessment center stated that it was “ingrained” in her to want to help people (Ogilvie, May 2, 2020, *The Toronto Star*). A nurse who was being evicted stated that she did not need to be troubled by issues from her landlord at this time, as she needed to go to work and “completely focus” on her patients (Monsebraaten, April 6, 2020, *The Toronto Star*). These articles demonstrate how nurses may be internalizing the caring discourse; to not be at work helping their patients seemed to cause these particular nurses’ great anguish. Issues of safety around PPE were not at issue here, but these nurses are described as desperately wanting to be at work so they could help.

The caring discourse extends to what nurses are and are not allowed to speak about. Nurses are penalized if they attempt to speak in medical terms or policy, but not if they talk about caring, advocacy, or holism (Gordon & Nelson, 2006). Depicting nursing as a profession that focuses on holism reduces the profession to the perception that these skills are not an acquired, but instead innate (Nelson & Gordon, 2006b). All of this obfuscates the real value of a nurse, which is that nurses are equated with improved patient recovery and survival (Gordon & Nelson, 2006). The argument that caring skills are innate leaves them open to self-blame for their

failure to care, when it is the environment that is making some tasks impossible (Nelson & Gordon, 2006a). For example, if a nurse is told a patient that they are uncaring for not doing something their employer prohibits them from doing, it is possible that they might take this to heart, especially if they take their duty to provide caring seriously. An emphasis on caring also leaves the door open for patients and families to blame nurses for their failure to care in a way the patient deems appropriate, when in fact it is the forced economic cutbacks that have made providing this care impossible (Nelson & Gordon, 2006a).

Dunlop (1986) points out that nurses cannot own caring, even if it is possible that nurses do care in a particular way. In reality, most interactions in the public sector are likely improved when approached with an attitude of understanding and empathy. Dunlop further points out that while the term caring certainly encompasses compassion, concern, and comfort, it is impossible to determine what each of these things mean for individual patient, as the definition of each of those terms will be highly contextual. This is particularly true for nursing, given the diversity of places that nurses work in and the huge diversity of clients they care for. Dunlop concludes that caring cannot be context free, in spite of the attempts of theorists like Watson, Benner, and Leininger to make it so. Caring developed in an historical context which means that we cannot just ignore the historical associations of the word with the profession (Dunlop, 1986).

The association of caring with sacrifice also has repercussions. For example, sacrifices can include time and energy. Emotional labor, which can be associated with caring and requires both energy and time, involves many different facets and can result in nurse burnout (Delgado et al., 2017; Kinman & Leggetter, 2016). Emotional work of any type requires expertise (Nelson & Gordon, 2006a). Expertise not only implies a skill that is learned, but also a skill that requires time and energy. However, attempts to cut costs at many institutions worldwide has resulted in

these invisible skills being devalued (Nelson & Gordon, 2006a), due to the fact that it can be difficult to articulate the precise skill sets involved in something as complex as emotional labor.

Another aspect of caring to consider is the potential economic importance of caring to those who employ nurses. Caring is a commodity, one that could serve to attract patients to their site. Caring nurses have been identified as a key component of a patient's experience, with patients separating 'good' and 'bad' nurses by focusing on their perception of a nurse's caring skills (Davis, 2005). Furthermore, the healthcare system is dependent on the idea that nurses will do whatever it takes to be caring, which may result in some self-sacrifice on behalf of the nurse (Dahlke & Wall, 2017). Nelson and Gordon (2006b) describe posters found in hospitals, depicting nurses as sweet, smiling, and virtuous, whereas physicians are invariably posed with their arms folded, looking serious. Nurses are generally found to be smiling, whereas physicians (male or female) are depicted as deep in thought while at work (Nelson & Gordon, 2006b). While the discourse of caring benefits the institution, it does little to benefit the nurse economically (Nelson & Gordon, 2006). In sum, caring theorists elevate caring above the many other skills that nurses have, is grounded in non-specific and relatively ambiguous theory, which risks devaluing nursing as a skilled profession (Aranda & Brown, 2006; Gordon & Nelson, 2006).

6.1 Strengths and Limitations

A strength of this paper is that it provides a concrete example of how the discourse of caring impacts nurses. Caring is often discussed in terms of how it affects the perception of nurses, but here it is possible to see that there are many ways the discourse can impact nurses. I have offered an historical analysis around how the discourse of caring that relates specifically to the safety of nurses. It is my desire that nurses may read this and perhaps begin to identify the

ways that this association affects their daily practice and limits their behaviors or ability to advocate. This paper also touches upon the provincial neglect of nurses' safety, in spite of the report issued in the aftermath of SARS, thereby noting what can be described as a trend in the behavior from the government towards the healthcare profession. Noting these trends are important for the future protection of all healthcare workers.

One of the limitations of this study was that the majority of my results in the archive originated from one newspaper (*The Toronto Star*). While other newspapers were certainly included in the analysis, it was simply a fact that the majority of articles that related to this topic were published in *The Toronto Star*. This was not due to any perceived bias in the selection process, but more likely due to the nature of the publication itself. It is possible that *The Toronto Star* focusses more on human interest stories than the other publications. However, *The Toronto Star* is a widely read newspaper in Ontario. There therefore would have been a large population who had access to these papers, meaning these articles would have had a wide impact.

Another limitation may be that the study was the study was confined to the province of Ontario. It is possible that nurses in other provinces and countries had much different experiences during the COVID-19 pandemic. While I did select to focus on Ontario, I chose to use national newspapers in my archive, meaning that they would have been widely read across the country. This indicates that the issues may not have been confined specifically to the province of Ontario. Certainly, the issues with supply were consistent across Canada. In addition, it seems unlikely that the discourse of caring would have developed in any substantially different way across the provinces, with the probable exception of areas with large indigenous populations or on indigenous reserves. Areas with vastly different cultural values and practices will have likely experienced the discourse of caring in very different ways.

6.2 Knowledge Translation

The primary reason for undertaking this project was to alert nurses to the importance of representation, and the ways that this can affect their lives and daily practice. Like most health care professions, nurses typically receive a limited amount of education in school regarding the history of their profession. It is essential to understand that representation and history are important, as it can shape other's perceptions of you, your access to resources, and, as in this case, even the ability to protect yourself. The purpose of this project is therefore to help to educate nurses on understanding the origins of the association of caring with nursing, and to demonstrate what impact it may have on them.

A value-added aspect of this research is the realization or knowledge that texts and norms are not neutral. Texts generally represent the dominant ideologies of the day as well as the particular viewpoint of the author. Statements that appear as self-evident, such as the idea that all criminals should go to prison (or be punished), for example, are actually representative of the dominant ideology of that time. Statements such as these need to be unpacked fully in order to be understood for what they truly represent. For example, many some authors write that prison is actually a public health issue, as many individuals who are incarcerated are in fact suffering from problems with addiction and/or problems with their mental health (Blunt, October 2019; Young, 2006). Prison can therefore be seen as a failure of public health instead of a system of correction, since prisons are not built or funded to treat either one of those issues. So, representation is not a straightforward affair; any act of representation necessarily has a number of built in assumptions. Nurses need to be aware of the ways that they are represented not only in the media, but in the literature put out by their own regulatory bodies. This act of representation and speaking for nurses ultimately impacts nurses' ability to act outside of the confines of this representation with

any degree of certainty. Challenging the dominant discourse may have beneficial impacts on the nursing profession as a whole.

The intended audiences for this project are nurses and nursing theorists. It may also interest readers who are interested generally in discourse analyses and could potentially serve as a template for future studies. There is a potential to open up a dialogue within workplaces around the placement of caring in nursing or even what nurses consider the essence of nursing to be. Such a discussion may serve to highlight the tension between the desire of the employer to have caring nurses and the impact that caring has on the nurse themselves. Providing awareness to nurses on the real-world impacts that caring has on their mental and physical health will allow nurses to engage more thoughtfully in these types of discussions.

Educating non-nurses on the role of nurses and the placement of caring within the profession is another a goal of this paper. Non-nurses will likely not have considered their own expectations of nurses, and a paper such as this one may allow them to re-evaluate them. Re-educating non-nurses on the skills that nurses possess and the important roles that they play within the medical system is important if the conversation is to move away from caring. Sharing the potential harm that the caring discourse can have on the nursing profession may help to shift the public narrative of nursing away from caring. This study may also serve as a guideline for future policy and publications. Ensuring that policy and publications are written in a way to distance nurses from the caring discourse may be of interest to different types of nursing associations, such as the RNAO.

6.3 Future Studies

There was much that could not be covered in this study due to limits of space and time. The discourses of caring and nursing intersect with so many other discourses that a full

evaluation of all of the discourses that intersected with the caring discourse would require much more space than is allotted here. Future studies could focus on the impact of race on the caring discourse, as most (if not all) nurses that entered the profession during the Victorian era would have been white. The discourses of war, motherhood, infectious disease, public health, religion, and gender have all made noteworthy appearances in the caring discourse. Unfortunately, in depth discussion around most of these topics were beyond the scope of this paper. They are all big topics, and certainly are all deserving of their own discourse analysis. In addition, a more detailed look at the discourse of caring in the first half of the 20th century would be useful, as that was beyond the scope of this study, due to the fact that many of the materials were not available to this author for review. It would be interesting to see how the concept of caring actually shaped the development of the profession.

This analysis was conducted using a gendered lens, which means that I was looking at the way the discourse originated from gendered ideas about the nursing profession. I did not study the impact the discourse had on nurses of different genders. As such, male nurses were subsumed into this discourse. However, male nurses may have had some markedly different experiences within the discourse of caring that would be extremely beneficial to explore. For example, one study found that male nurses tend to demonstrate their care in different ways (Zahourek, 2016), while another found that male nurses suffered from many gendered stereotypes as well, including the perception that that they do not care (Younas & Sundus, 2018). A breakdown of how caring is perceived by different genders might therefore be a useful future study.

Another future study of interest would be focused on the work of personal support workers (PSWs). The work of PSWs and nurses often intersect. However, PSWs are not a regulated profession in Ontario. This means that they may suffer from some similar burdens of

nurses but have even fewer recourses to address them. PSWs remain a large part of the caring discourse, although they are not often addressed. For example, while conducting the research for this study, it came to my attention that PSWs were also often deprived of PPE. In addition, they often make up the majority of staff of many LTCHs in Ontario. LTCHs in Ontario were particularly impacted by COVID-19. A future study examining this particular intersection would be of interest. PSWs fought many of the same wars that nurses fought during COVID-19, if not more, as there are very few jobs that a PSW performs that does not require getting up close and personal with the client.

6.4 Final Remarks

Caring is an historically loaded word and positioning it as the essence of the nursing profession has real-world implications for nurses. It is important to detach nursing from these historical origins and move it forward so that nurses are no longer expected sacrifice themselves in the pursuit of their profession. Not all nurses are caring, and on some levels, this should not matter. Nursing is a skill-based profession and establishing therapeutic relationships with clients is one of those skills. Author John Paley (2002) suggests that the essence of nursing may be the focus on recovery and rehabilitation, and this strikes me as an accurate description that covers most areas of nursing. Altruism and sacrifice can be extremely meaningful acts, but they should not be expected from a profession as a whole. Nurses should not place the burden of caring on themselves unnecessarily, particularly when they live in a society that seems to continuously be removing the supports that nurses need to have in place in order to provide that care. Caring should remain a choice, not a duty.

The discourse of caring still significantly impacts nurses' ability to act autonomously and with authority. There are expectations placed on the profession as a whole that are not placed on

physicians. Nurses operate under the auspices of autonomy and advocacy, but the discourse of caring silences them through the cooptation of their right to speak by experts, their places of employment, and other regulatory bodies. In patrolling the behavior of nurses and labelling advocacy as insubordination or unprofessional behavior, nurses are at risk of not only losing their jobs but of being disciplined or even expelled from their own profession.

Caring is a useful attribute in many professions and should not be seen as a bad thing. However, there needs to be a recognition that caring is a skill, and that it depletes emotional capital to continually care for everyone. There is also the question of whether or not a nurse could successfully complete their job if they did not care. Instead of reframing unpleasant tasks such as restraining a patient as a caring act, nurses should look at their roles more critically, and remove the caring stigma. Measuring a nurse's act in increments of caring should not be how nurses are evaluated by nurses, non-nurses, their employers, or the regulatory body. Removing the association of caring with nursing can only move the profession forward. It is essential to get the general public on board with this re-framing of the profession, so that their expectations of what a nurse does can be modified to fit in with reality.

Declaring caring as the essence of nursing highlights the privilege of those who were able to enter the profession simply to 'care' for others. Nurses enter the workforce for many reasons. To elevate the profession to something beyond a simple means to make a living hints at some underlying privilege. There is an assumption that the reason nurses became nurses is because they felt compelled to provide care in some way. This assumption was reflected in the depiction of some nurses within the archive.

There is no agreed upon definition of caring. Not all people experience caring in the same way. A nurse may believe that their actions are caring, but others may not experience it in that

way. We don't all experience or provide care in the same way; caring behavior cannot be defined, leaving nurses open to constant failure if a patient or other staff accuses them of being uncaring. This places nurses in the precarious position of having to provide something that they are always at risk of being told they did not provide. It places nurses in the position of trying to provide caring 100% of the time, but with little guidance on how to handle the multitude of situations and multiplicity of clients that they are likely to encounter over the course of their career. This could lead to feelings of inadequacy, ineptitude, or an inability to be fulfilled. With the conflation of the professional and the personal, nurses who do not "achieve" caring may take these failures personally.

Nursing during a pandemic has put many of these issues at the forefront of the discussion around healthcare and nursing. At a time when safety is of the utmost importance, nurses are still expected to provide caring, even if this means self-sacrifice. The denial of PPE to many of Ontario's nurses during the COVID-19 pandemic as well as the SARS epidemic has highlighted the ways in which the province and the public expects nurses to be there for them, no matter what the cost. While all healthcare professionals enter the profession knowing that they will be in contact with contagious diseases, it is not logical to assume that they believe it is acceptable to do so without the proper protection. The recommendations made in the aftermath of the SARS epidemic were eventually forgotten, placing nurses in a similar situation during the initial stages of the COVID-19 pandemic. This fact has highlighted the fact that nurses are not generally included in the decision-making process around what they require to keep themselves safe. The practice of speaking for nurses and expecting compliance from them can unfortunately only serve to harm the profession and individual nurses. Caring should not mean that nurses do not have access to the means to protect themselves.

This study has highlighted a few of the ways that the discourse of caring can harm the nursing profession. The expectation that nurses must be caring may result in placing nurses in unsafe situations or asking nurses to do things they are not comfortable with doing. Non-nurses need to be educated around what nurses actually do without reference to the caring discourse, as if a nurse is perceived to be non-caring by the patient, they may be labelled a “bad” nurse. If a nurse declines to perform unsafe work, there is a danger that they will be labelled uncaring. Or, there may be attempts to force the nurse to perform unsafe work, as there were during the COVID-19 outbreak in Ontario in the Spring of 2020. The expectation that nurses are meant to practice acts of self-sacrifice in order to fulfil the tenets of their profession may result in real harm and threaten a nurse’s safety. Other themes related to the caring discourse, such as love, motherhood, or even the thoughts around caring as an act of transcendence, conflate the personal and professional. This conflation of identities can only serve to confuse both nurses and non-nurses as to the true skills required to work in the profession. Nursing has proven difficult to define as a whole, but perhaps in order to move forward, we must stop looking to the past.

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Appendix A: Critical Discourse Analysis

The purpose of this appendix is to provide further context around the distinction between a Foucauldian discourse analysis and a critical discourse analysis (CDA). The body of this project discussed the main components of a Foucauldian discourse analysis. While many authors use the terms Foucauldian discourse analysis and critical discourse analysis interchangeably, there are differences between the two methods. Both approaches are rooted in poststructuralism, however, the methods used can be quite different. Since the body of the paper describes the theoretical foundations and methods of an FDA in full, I will only describe CDAs here and then comparing and contrasting the two methods at the end.

Critical discourse analyses have become a popular method of analysis in many fields of research. The foundations of the CDA are built on the shoulders of FDA, a fact that no doubt acts as the source of the confusion over the two methodologies. CDAs generally agree with Foucault's notion of a discourse, but the methods used to mine the details of this discourse are different (Jahedi, Abdullah, & Mukundan, 2014). CDAs place their origins not only in the work of Foucault, but in critical linguistics, Western-style Marxism, sociology, and author Mikhail Bakhtin, who wrote extensively about intertextuality and linguistics (Fairclough, Mulderigg, & Wodak, 2011).

The term CDA tends to be used somewhat loosely, with many authors relying heavily on a linguistic analysis, while others take a different type of "critical" analysis, such as feminism. CDAs were championed by Norman Fairclough and he is considered to be one of the most influential practitioners of CDA (Poole, 2010). Fairclough's *Language and Power* is generally considered to be a seminal text in the world of CDAs and is generally regarded as the official starting point for CDAs (Blommaert & Bulcaen, 2000). Fairclough's influence is immense, but

there are other major players in the field of CDA, such as Ruth Wodak and Teun van Dijk. Each author has their own specific approach to CDA. Each approach focuses on different perspectives, including linguistics, ethnography, and socio-cognitive approaches (Jahedi, Abdullah, & Mukundan, 2014). 2011).

Unlike an FDA, the analyses in a CDA are very much linguistically based, often including a focus on phonology, sentence structure, semantics, and even an examination of the ways in which the conversation is organized (Fairclough, 1992). The precise mode of investigation is left up to the researcher to decide upon, meaning that various linguistic techniques and theories can be used (Fairclough, Mulderrig, & Wodak, 2011). While the analyses are not restricted to strictly linguistic methods, the overarching feature that ties each analysis together is that they are linguistically based.

Goals of a Critical Discourse Analysis

It is in the goals of the analysis that a CDA most obviously differs from an FDA. Like an FDA, the focus of the analysis is on the ways that language can be representative of unspoken or assumed truths. Unlike an FDA the explicit aim is change (van Dijk, 1993). The explicit purpose of a CDA is to address social processes and problems, with political and social action forming the underlying principles of a CDA (Breeze, 2011; Fairclough, Mulderrig, & Wodak, 2011). CDAs can be used as a means to understand complex social issues and its authors are expected to take an explicit sociopolitical stance with an eye towards change (van Dijk, 1993). The targets of their critiques are those that help to maintain social injustices (van Dijk, 1993).

The political nature of CDAs means that the authors are committed to righting what they consider to be wrongs (Fairclough, Mulderrig, & Wodak, 2011). Many of the most popular topics for CDAs focus on areas where there is a perceived need for change (Blommaert &

Bulcaen, 2000). They are not intended to be apolitical treatises, but are expressly intended to foment change (Fairclough, Mulderrig, & Wodak, 2011). As such, authors of CDAs are committed to change, empowerment, practice, and interventions (Blommaert & Bulcaen, 2000). CDAs are not only political in nature. There is an explicit intent to not only highlight injustices, but to offer solutions to problems and to offer ways past many obstacles (Blommaert & Bulcaen, 2000; Chouliaraki & Fairclough, 1999). This makes them emancipatory in nature, as the authors will always take the point of view of those they consider to be oppressed (Fairclough, Mulderrig, & Wodak, 2011).

Similarities and Differences between an FDA and a CDA

As discussed above, there is a fair amount of overlap between an FDA and a CDA. Both types of analyses are critical in nature and share some of the same methods, so it is certainly not surprising that there is some confusion between the two. Both take critical stances in examining the ways in which our identities are formulated and sustained via societal norms. There is a focus on power relations in a CDA, just as there is in an FDA (Fairclough, Mulderrig, & Wodak, 2011). Both CDAs and FDAs are intended to be used to explore the relationships between power and ideology via analysis of discourse (Blommaert & Bulcaen, 2000). Both believe that discourse is historical and that the process of interpretation can vary from author to author (meaning that neither CDAs nor FDAs use any fixed set of research methods). All forms of CDAs are seeking to provide insight between the correlations of language, power relations, and ideology, and share that in common with an FDA (Jahedi, Abdullah, & Mukundan, 2014).

In a CDA, the discourse is largely only textually analyzed and remains overtly linguistic in its methods and outlook, differentiating it from FDAs (Blommaert & Bulcaen, 2000). There is a focus on the text in a CDA that can detract from the usability of the analysis, making this the

distinguishing feature between a CDA and an FDA (Blommaert & Bulcaen, 2000). The major difference between the two remains in the goals. As discussed above, Foucault never wanted his work to be perceived as political, nor was he attempting to advocate for major change. His interests seem to lie in tracing the effects language (or discourse) has on the body. Proponents of the CDA have taken up Foucault's emphasis on the centrality of language in the discourse, but not necessarily the identification of the discourse in the real world (Breeze, 2011).

In order to remain true to the tenets of either field, any author undertaking a discourse analysis should critically examine what the intended goals of the study are meant to be. While the techniques of analysis are certainly flexible within each field, the goals of each type of analysis are quite different. It is essential that researchers clarify what the goals of the analysis are going to be prior to embarking on the project, so that the appropriate amount of care can be paid to the methods of analysis. In addition, if an author does not intend to focus either on linguistics or adhere to Foucault's techniques in their analysis, the term discourse analysis should be used. Any discourse analysis is going to be critical in its outlook and it is unnecessary to specify that it is critical. Simply referring to the work as a discourse analysis removes any association with the more linguistically focused analyses contained within CDAs. This is important because the term CDA is so closely associated with Norman Fairclough and critical linguistics that using that phrase outside of that particular framework does tend to cause some confusion.

In sum, discourse analysis is a diverse field, making it difficult concisely explain. There is much overlap between the methodologies and methods. The result has been that authors are generally free to construct the analysis in the way that they find most useful. The key is to provide structural integrity to the project and to be consistent throughout the work in the

application of methods. All discourse analyses are critical in nature by their very definition and highlighting that fact may lead to some confusion due to the strong association between CDAs and more formal linguistic analysis.

Appendix B: Summary of Analysis in Relation to Powers' (2013) Framework

While many of the questions formulated by Powers (2013) and presented in the body of the thesis as a table were naturally addressed throughout the body of the paper, for reasons of clarity I have attached a summary of responses here. The purpose of doing this is to ensure methodological adherence and clarity while not disturbing the structural integrity of the thesis.

Table 3 Powers' (2013) Guide to Conducting an FDA (With Answers)	
Genealogy	
Q: What other discourses or events provided models or ideas that influenced the functioning of the discourse under analysis?	A: Some of the other discourses that have influenced the functioning of the discourse of caring are the discourses of war, public health, safety, sacrifice, and motherhood. Starting from the 1970s, the discourse of feminism further influenced the functioning of the discourse.
Q: What words in the discourse have a linguistic and social history that is significant for assessing the order of the discourse within current power relations?	A: In relation to the archive, there is considerable overlap in the archive between the discourse of caring and the discourses of war, with the point of similarity between the two being the concept of sacrifice or altruism. In more general terms, self-sacrifice, love, and morality have all played an important role in the development of this discourse.
Q: What historical context influenced the development of the discourse?	A: The historical conceptualizations of gender, identity, and biological differences between the sexes have considerably influenced the formation of the discourse, with the locus of control located in the differentiation between the public and private spheres in Victorian England.
Q: What physical bodily space was created by being described by the discursive practices of the discourse?	A: The rights of a nurses to protect their bodies as they saw fit was the bodily space occupied. The tenets of infection control, including the difference between droplet and airborne precautions, and the different mask types that could be used to do so, were intrinsically linked to this argument.
Q: What surfaces of emergence and conditions of possibility were acknowledged and	

appropriated by this discourse?

A: Other platforms that may have served as platforms for these discussions were discussions around infectious disease and SARS. This was demonstrated in the results sections that infectious disease specialists were invested in the argument around what types of masks should be available to nursing staff. SARS was also brought in as a comparison to the current situation and in essence, the two situations were extremely similar.

Q: By what processes did the discourse construct the right to pronounce truth?

A: The truth was initially propounded by nursing theorists, the nursing regulatory body (the CNO), the RNAO, and the institutions that nurses worked for.

Q: By what processes did the discourse construct the right to pronounce truth in some region of experience?

A: The hospital system was initially constructed to reflect the patriarchal construction of society (Hawkins, 2010a). The roles within the system were based on the Victorian era gendered conception of society. Nurses served as replacements for family members. These roles were perpetuated within the healthcare system until the gendered division of labor was challenged in the 1970s. The archive perpetuates this conceptualization of nurses through the “feel-good” stories, which was comprised of stories that included depictions of nurses comforting patients, often by holding their hand or standing in for loved ones when they could not be present.

Q: What other discourses were affected and how?

A: It is difficult to know what other discourses have been fully impacted by this. The discourse of infection control and the authority of infectious disease specialists may have been impacted due to the fact that nurses eventually won the right to choose what level of PPE they wanted to wear. It also entered into the realm of public health and who controlled the safety of healthcare workers: the experts/authority figures, the government or those who worked within the system. The government is included here because of the fact that they were in charge of overall mask distribution and allotted where masks went.

Q: What power struggles or turf battles occurred and what was the outcome?

A: Again, the primary turf battle was around who decides to control the discourse of infection control: the experts, the institutions, or those who are working on the front lines. The only reason the issue was resolved was because it was taken to court.

Q: In whose interest was the social construction of this discourse?

A: Initially, nurses benefitted from the construction of this discourse, as it provided women the means to work outside of the home without disrupting any social norms. As time passed and certain societal values changed, the discourse was viewed as somewhat outdated by some nursing theorists and feminist scholars. The construction of this discourse benefitted the structure of the

healthcare system. It also benefits physicians, as noted by Peplau (1999), as having nurses providing care freed up their time to pursue research.
<p>Q: Whose interests were ignored and/or rejected?</p> <p>A: Ultimately, it has been nurses who have not benefited from this discourse, as it may place an unfair burden on nurses emotionally. It may also detract from the specific skills that nurses have. Certainly, restricting access to N95s was an example of the way that nurses' interests were ignored and rejected.</p>
Structural Analysis (3 parts)
Axis of Knowledge (i)
<p>Q: What is it that guides this discourse?</p> <p>A: What really guides this discourse is the idea that women are naturally more inclined to act in a caring manner than men. In addition, the division of labor between physicians and nurses means that physicians are more often associated with technical skills and scientific research, whereas nurses are associated with caring acts. This was demonstrated in the archive with the nursing stories associated with feeling good, and the depiction of physicians performing skills more often than nurses were.</p>
<p>Q: What regularities can be discerned?</p> <p>A: Nurses were less likely to criticize their employers or the government response using their own name, nurses were depicted more often as expressing concern about their families, nurses were less likely to be depicted performing technical work, nurses were more likely to be featured in stories about "caring" such as making friends with patients, standing in for family members at the bedside, etc., there was a tendency not to give nurses a name within the newspaper articles and depict them more as interchangeable, and nurses were more likely to be actively denied access to PPE.</p>
<p>Q: What processes differentiate the subjects and objects of the discourse?</p> <p>A: Nurses and nursing students are differentiated by education. Nursing students have a preconceived idea of caring that changes once they enter the clinical environment (Dobrowolska & Palese, 2016). In addition, caring is often presented as a normative value in nursing textbooks and in the education of nurses (Dahlke & Wall, 2017).</p>
<p>Q: What processes produce the physical space, the meaning, and assumed truth of the discourse?</p> <p>A: Caring has been an assumed component of nursing for at least the last 100 years. It continues to be propagated by nursing authorities (CNO, RNAO), nursing theorists (such as Watson and Leininger), and through the education system. The convergence of influences is multipronged.</p>
Q: What does the discourse do to the resulting subjects?

A: The subjects may internalize the discourse (Dahlke & Wall, 2. For example, in the archive there were three examples of nurses who stated it was either their duty to care or felt worthless as a result of the fact that they could not work (Grant & Mahoney, March 30, 2020, *The Globe and Mail*; Keung, April 1, 2020, *The Toronto Star*; Monsebraaten, April 6, 2020, *The Toronto Star*). In addition, the conflation of the personal with the professional in many of the nursing theories could ultimately cause a nurse to take any complaints around a perceived lack of caring personally. It may also result in nurses taking on additional emotional labor, which can result in nurse burnout (Valiani, 2003).

Q: How do individual differences, deviations, and complaints emerge in the formation of subject to object?

A: Caring is very loosely defined (Paley, 2001). As such, it is possible to re-define caring to suit any environment. For example, Dahlke, Phinney, Hall, Rodney, and Baumbusch (2015) provided the example of reframing the use of restraints on a violent or unstable patient as a caring act, since it actually stops the patient from hurting themselves. Caring is therefore flexible enough for all people and environments.

Q: What authorities of delimitation exist?

A: The only delimitation of the discourse are issues related to emotional exhaustion (Valiani, 2003). An extension of that may be the establishment of boundaries with patients.

Q: What are the rules of evidence of the discourse?

A: Evidence around caring has been provided in the form of the quantitative measurement of caring via caring scales (Tatano Beck, 1999). Evidence is also provided by nursing caring theorists, who extol the benefits of caring to their audiences.

Q: What order governs the multiplicity and diversity of the subjects?

A: Again, due to the very nature of the term, caring can be defined as necessary to suit the situation as well as the individual.

Axis of Authority (ii)

Q: What are the rules for who is allowed to speak and who is not?

A: Those with authority are allowed to speak. For nurses, these are the regulatory institutions and governing bodies. It was the intervention of the ONA that ultimately ended the battle over access to N95s, as it was the ONA that took the case to court. Individually, nurses' voices were not heard. Not only that, but there was a pattern of silencing nurses, either through the fear of retribution or through a sense of mistrust (Arthur, March 30, 2020, *The Toronto Star*; Arthur, May 19, 2020 *The Toronto Star*; Cribb, May 4, 2020 *The Toronto Star*; DiManno, April 1, 2020, *The Toronto Star*; Donovan, April 7, 2020, *The Toronto Star*; Li, April 24, 2020, *The Toronto Star*; McKinley, April 20, 2020, *The Toronto Star*; National Post, April 1(i), 2020; The Toronto

<p>Star, April 20, 2020; The Toronto Star, April 28, 2020; Welsh, April 30, 2020, <i>The Toronto Star</i>).</p> <p>In addition, those who had access to scientific data were allowed to speak. It was infectious disease experts who spoke on behalf of nurses, with science as the source of their authority (Cribb, May 4, 2020, <i>The Toronto Star</i>; The Toronto Star, April 20, 2020; Ward, March 15, 2020 <i>The Toronto Star</i>; Weeks, March 11, 2020, <i>The Globe and Mail</i>; Weeks, April 3, 2020, <i>The Globe and Mail</i>).</p>
<p>Q: How is the discourse preserved, transmitted, disseminated?</p> <p>A: Hospital ads depicting nurses as smiling, open, contrasted with pictures of physicians with their arms crossed and looking serious (Nelson & Gordon, 2006b) is one means used by facilities to perpetuate the discourse. Dissemination occurs again through the CNO and RNAO, as they set the industry standards and regulations for the profession.</p>
<p>Q: What systems are allowed for education and advancement of members of the discourse?</p> <p>A: There are no restrictions around education and advancement for the members of this discourse. There is no specialized learning necessary to “care”.</p>
<p>Q: How is the right to pronounce truth preserved?</p> <p>A: Control of the discourse is maintained through nursing educational facilities, provincial nursing organizations, and nursing theorists.</p>
<p>Q: What speaking positions are available to people within this discourse? What words can be used?</p> <p>A: Some of the words discussed in this work that can be used in association with this discourse are many: virtue, morality, love, emancipation, feminine, social justice, mindfulness, loving-kindness, culture, holism, sacrifice, and altruism.</p>
<p>Q: What speaking positions are not allowed?</p> <p>A: The contemporary version of the discourse of caring does not include space for reference to gender. References to the subservience of nurses to physicians have been removed.</p>
<p style="text-align: center;">Axis of value (iii)</p>
<p>Q: What social agents are mobilized in order to control the deployment of the discourse and how are they trained?</p> <p>A: The newspaper articles themselves actively perpetuate the discourse of caring through their descriptions of nurses and how nurses are depicted in their articles.</p>
<p>Q: How does the discourse justify the technologies of power that it constructs for its purposes?</p>

A: Advocates of caring justify their position by referring to caring as the essence of nursing.
<p>Q: How does the discourse justify suppressing other discourse that challenge its dominance in pronouncing truth?</p> <p>A: Dissenting discourses are not necessarily addressed. The nature of the discourse of caring means that the definitions that are used within it are fluid. There are a multitude of caring theories, making it difficult to argue against all of them cohesively. Internal exclusions to the discourses, such as nurses who harm, are also not addressed by the discourse. The regulatory body uses the disciplinary committee to chastise nurses, but their process does not address caring directly. Instead, they refer to disgraceful or dishonorable acts (CNO, July 25, 2017).</p>
<p>Q: What justification is provided for the punishment of participants?</p> <p>A: The CNO disciplinary committee functions as a means of punishment. It enforces the standards of the profession.</p>
<p>Q: What is the justification provided by the discourse for its position as a pronouncer of truth?</p> <p>A: The justification used is that they proclaim caring to be the essence of nursing. One of the few challenges to this came from Paley (2002), who wrote that recovery and rehabilitation could possibly function as the essence of the nursing profession. However, this position has not been taken up by other authors, to the best of my knowledge. The discourse of caring operates uniquely, without any real competitors.</p>
Power Analysis
<p>Q: In whose interests is the continuation of the discourse?</p> <p>A: Employers can benefit from the continuation of this discourse, as portraying a facility as staffed with caring nurses can conceivably be seen as a selling point. Hospitals will advertise caring nurses (Nelson & Gordon, 2006b). Patients want to have caring nurses (Davis, 2005), and a facility that provides that may benefit financially from describing their nurses as caring.</p> <p>Physicians may benefit from this discourse, as being considered exempt from providing caring behaviors has, in the past, provided them with additional time to spend researching and studying (Peplau, 1999).</p>
<p>Q: Whose autonomy and responsibility are enhanced by this discourse?</p> <p>A: In general, physicians reap the benefits of this discourse. This is in line with the historical development of the discourse, as it was initially modelled on societal norms that supported a patriarchy (Hawkins, 2010a). Physicians are given more choice overall in the workplace. In the example of SARS, some physicians chose not to wear PPE, and it was nurses who needed to remind them to wear it (Campbell, 2006a). Some physicians outright refused to wear PPE or go through the SARS screening everyone else had to go through to enter the hospital, or follow</p>

other protocols (Campbell, 2006a). Physicians were also listened to by management more than nurses, in spite of the fact that it was nurses, not physicians, who were working at the bedside (Campbell, 2006a). Physicians were able to see patients virtually and were directed by their College to do so whenever possible (CPSO, 2020).

Q: Whose autonomy and responsibility are reduced?

A: A nurse's autonomy and responsibility are reduced. Nurses are penalized if they attempt to speak in medical terms or policy, but not if they talk about caring, advocacy, or holism (Gordon & Nelson, 2006). In addition, a nurse's right to refuse work is also more limited than a physician's (see CNO, 2017; CPSO, 2020). Nurses are directed to exercise their autonomy and advocate, but are in fact given little space to do so.

Q: What dominations are established, perpetuated, or eliminated?

A: While subservience to physicians has been removed from the discourse, there does remain an implicit hierarchy between nurses and physicians, with physicians freer to refuse to work than nurses.

Q: What sub-discourses of resistance are present within the discourse?

A: The sub-discourses of resistance are represented by nursing theorists who contend that caring is not the essence of nursing.

Q: What mechanisms are in place for the systematic co-optation of resistance discourses?

A: None. While caring is referred to in the regulatory and professional nursing literature, it is not used as a means to discipline nurses explicitly. Instead, nurses are held to the professional standards listed in the practice standard *Professional Standards, Revised 2002* (CNO, 2018) and *Code of Conduct* (CNO, 2019b).

Q: Whose voice is being heard?

A: Often, it is nurses' voices that are being heard when caring is discussed. All of the caring theories presenting in this study were written by nurses. In the archive, it was the authors of the newspaper articles voices' that we were hearing, as they depicted nurses performing caring acts.

Q: Whose voice is being left out?

A: Nurses who do not agree that caring is the essence of nursing. Dahlke and Wall (2017) discussed the possibility that an emphasis on caring may actually stop nurses from speaking out, as they do not wish to be perceived as uncaring.

Q: Do individuals feel constraints against speaking?

A: Yes, nurses felt constrained against criticizing in the archive. Also, as Dahlke and Wall (2017) discuss, an emphasis on caring may actually contribute to nurses' silence on issues around their

practice.

Q: Are all voices equally informed?

A: No. The variability of the profession means that there are many different perspectives on the issue of caring in the nursing profession. Ultimately, however, the voice of the CNO and the RNAO lend great credence to the presence of caring in nursing.

Q: What power relations exist between this discourse and others?

A:

Curriculum Vitae

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